Nursing in Wartime

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THE COVER

The Vietnam Women's Memorial, dedicated at Constitution Gardens, Washington, D.C., November 11, 1993, is the work of sculptor Glenna Goodacre. Her final design was approved by the Vietnam Women's Memorial Project Board of Directors, the National Capital Memorial Commission, the Commission of Fine Arts, and the National Capital Planning Commission following a competition in 1990. The Veterans Day celebrations commenced with a Memorial March and concluded with a Candlelight Ceremony at the monument.

The cover photograph is by Gregory Staley, 1993, reproduced through the permission of the Vietnam Women's Memorial Project, Inc.

From her studio in Santa Fe, New Mexico, Goodacre modeled not only the four larger-than-life bronze figures but also the rawness of their emotions—their compassion, anxiety, fatigue, and dedication. It is the apparent depth of those feelings that makes the monument more than simply bronzed forms. Shaped first in clay and then sent to a foundry to be cast, the memorial is a permanent tribute to women who served during the Vietnam era.

The sculpture is composed in such a way as to be fully visible from any angle. It is the centerpoint of the site designed by George Dickie in "Area 1" of the Constitution Gardens maintained by the National Park Service. The viewer is drawn into the landscape and encouraged to move around the figures, capturing a series of successive images. The area can be entered from the main walkway to the Vietnam Memorial and the statue of the three fighting men. When departing, the visitor can see the Wall, the Vietnam Veterans Memorial.

The Vietnam Women's Memorial has been called by J. Carter Brown, chairman of the Commission of Fine Arts, "a metaphor for war as experienced by those whose heroic contributions have been so often ignored." The sculptor said, "That my hands can shape the clay which might touch the hearts and heal the wounds of those who served fills me with humility and deep satisfaction."

excerpted from Celebration of Patriotism and Courage: Dedication of the Vietnam Women's Memorial, November 10–12, 1993 *(Washington, D.C.: Vietnam Women's Memorial Project, 1993)*

An Introduction: Faintly Heard and Little Noted

Nursing has its roots in wartime service, although its relationship with war has rarely been acknowledged. The great advances and notable achievements made by nurses during wartime are faintly heard and little noted.[1] The service of those "forgotten veterans" who rose to the unique circumstances of war to care is not well known and has received relatively little attention. Servicemen, however, have responded to the comfort, compassion, and care of nurses with overwhelming gratitude:

> To all Army nurses overseas: We men were not given the choice of working in the battlefield or the home front. We cannot take any credit for being here. We are here because we have to be. You are here because you felt you were needed. So, when an injured man opens his eyes to see one of you . . . concerned with his welfare, he can't but be overcome by the very thought that you are doing it because you want to, . . . [Y]ou endure whatever hardships you must to be where you can do us the most good.[2]

This tribute to nursing appeared during World War I.

Monuments to Forgotten Veterans

It is thus surprising that approximately 35,000 people witnessed a dramatic event that occurred on Veterans Day, 1993, in Washington, D.C., when the Vietnam Women's Memorial was dedicated.[3] The ceremony was the result of a decade-long struggle led by Diane

by M. Patricia Donahue
Guest Editor

Carlson Evans. A head nurse at a frontline Army unit in Pleiku, a village near the Cambodian border, Evans now serves as chair of the board of directors for the Vietnam Women's Memorial Project, Inc. She relates that, as with other matters concerned with the Vietnam War, the project was not without controversy and rejection. With incredible tenacity, perseverance, and teamwork, however, she and others overcame obstacles and made the project a reality.

The Vietnam Women's Memorial, a seven-foot sculpture by artist Glenna Goodacre, beautifully and poignantly portrays four figures: a nurse tending to the chest wound of a soldier lying across her lap; a woman scanning the sky for a helicopter or assistance; and a kneeling woman staring at an empty helmet, bowing her head in grief and despair. The Vietnam Women's Memorial provides the first visible symbol in the nation's capital that honors women's patriotic service. The memorial followed exhausting years of convincing the public of the need to honor female veterans—rallying financial support, lobbying Congress, and obtaining government support and permission.

Earlier monuments and memorials to American military nurses were located outside the nation's capital. Among the most impressive is the Nurses' Monument, located on a hilly slope in Arlington National Cemetery, which personifies a single figure—the "Spirit of Nursing"—in gracefully sculpted Tennessee marble. That monument, unveiled on November 8, 1938, was rededicated "to commemorate devoted service to country and humanity" on March 11, 1971, by chiefs of the Army, Navy, and Air Force.

Another imposing monument to nursing of a bygone era was erected to the memory of a single individual, Mary Ann Bickerdyke from Galesburg, Illinois. Affectionately known as "Mother" by the sick, wounded, and dying soldiers, Bickerdyke served as a nurse under fire in nineteen battles during the Civil War. The Bickerdyke monument was erected on the Public Square in Galesburg in 1903, an event made possible by an appropriation of $5,000 by the State of Illinois. In 1962, on the 125th anniversary of Knox College in Galesburg, Bickerdyke was remembered with a commemorative cover franked with a U.S. four-cent stamp honoring nursing.

Commemorating Nursing

The majority of memorials dedicated to nurses and nursing can be categorized as ecclesiastical, educational, or military. They represent varying methods for bestowing honor as through sculptures, cornerstones, scholarships, and stained glass windows. Those specifically associated with military nurses bear testimony to the strong relationship between war and nursing that became formalized during the Civil War.

From the earliest battles of that great conflict, the inadequacy of the military's medical support system was tragically exposed. Prior to 1861, voluntary societies had aided communities befallen by epidemics or other types of disaster. Women organized similar relief groups to provide some mechanism for furnishing medical supplies and nursing care to Civil War troops. Out of those societies

"Mother" Mary Ann Bickerdyke Memorial, located on the lawn of the Knox County Courthouse, Galesburg, Illinois

emerged the United States Sanitary Commission, whose mission was to improve conditions of battlefront hospitals and the general health of the Union Army and Navy.[4]

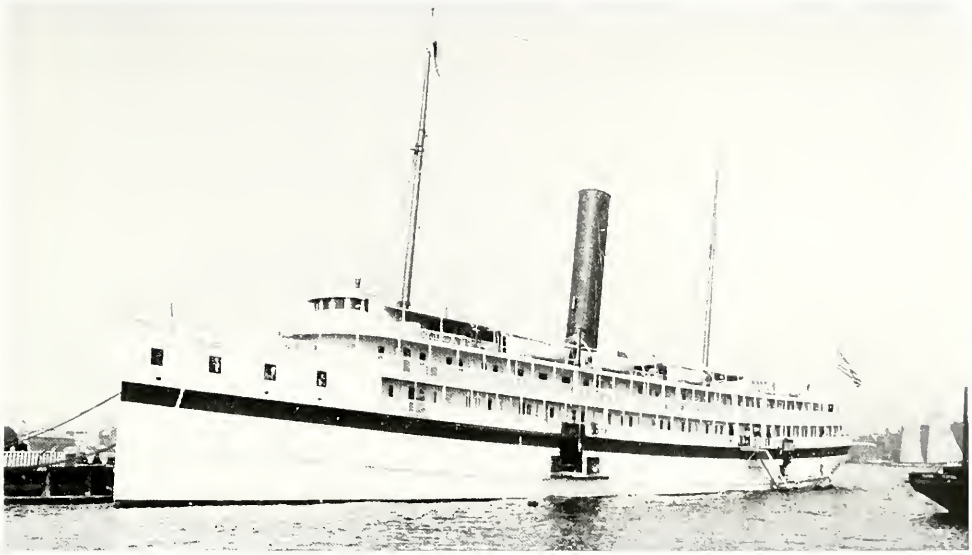
Nurses from the North and the South were not trained. They were usually women who volunteered their services out of feelings of patriotism and compassion. In addition to the remarkable feat of caring for the sick and wounded under deplorable conditions, the Civil War proved the importance of nursing, aroused public interest in nursing, and opened the door for the entry of women (nurses) into hospitals. Most important, it led to the movement for nurse training schools in the United States. Regrettably, however, it did not result in the establishment of a trained nursing corps in the United States military.[5]

By the time of the Spanish-American War, trained nurses were a reality. As news of the deplorable conditions in the hastily constructed army camps were made known—typhoid fever, malaria, dysentery, yellow fever, and food poisoning,—those nurses were quick to respond. Members of the Nurses' Associated Alumnae of the United States and Canada offered their services to the Army but were flatly rejected; instead, officials turned to the Daughters of the American Revolution for recruitment of nurses for the camps.[6] Eventually, graduate female nurses were employed by the government on a contractual basis, thus marking the earliest actual military nursing service. Nearly sixteen hundred nurses functioned in a subtropical climate without adequate resources in conditions of the worst type. Thirteen nurses died, and approximately 10 percent surrendered to a variety of diseases.[7] The superiority of the trained nurse over the untrained volunteer was proven once again. Immediately following the war, bills were proposed but not passed for the establishment of a nursing corps that would have the sanction and permanence of law. Not until February 2, 1901, was a permanent Army Nurse Corps created.[8]

This issue of *Caduceus* will examine the unique circumstances of war that illustrate the value of nurses. Through the reconstruction of nursing's past, much can be learned about society, the status of women, and the relationship of nursing to medicine and health care.

Nurses in the military have shared a tradition of service. They have played an important role in the care of military personnel and their families. They have assisted with the development of new techniques and innovations that have benefited medical and nursing care for civilians as well as soldiers

It can be argued that some significant events, persons, and places were omitted from this issue. Indeed, the articles were chosen to be a representation of the efforts of nurses in wartime since a comprehensive documentation was not possible. Only selected events, topics, and individuals could be highlighted. Together, they represent a larger body of information that demonstrate nursing's struggles, growth, challenges, dilemmas, humanitarianism, and beauty during wartime.



The Army hospital ship "Relief," presented to the United States government during the Spanish-American War by the Daughters of the American Revolution. Navy Nurse Corps Superintendent Esther V. Hasson wrote this account of that historic service for the March 1909 issue of the American Journal of Nursing:

> *Early in May of 1898 four women graduate nurses left Washington for Key West, Florida, under orders from the Surgeon-General of the Army to report to the medical officer in command of the military hospital at that place for such duty as he might assign to them. Little did the nurses of this country think, at the time, of the far-reaching results of this order and that these women were the nucleus around which would form, first the corps of contract nurses, and later on, in 1901, the permanent organization of the Army Nurse Corps as it exists today. Their plunge into this (to the average nurse of that date) unknown field of work was like unto the traditional pebble cast into the sea of military nursing. The tiny ripples set in motion have spread out in gradually increasing circles until the little group of women on the extreme outer edge who at present represent the nurse corps of the Navy are already beginning to wonder upon what shores the last ripples will break (pp. 410–11).*

Kathleen S. Hanson, Assistant Professor at the University of Illinois at Chicago, College of Nursing, Quad Cities Regional Program, provides an insightful look at female nurses in the Civil War. According to Hanson, the contributions of women serving as nurses during the Civil War changed the concept of women's roles at the battlefront and at home, gave the needed push for the inclusion of trained women nurses in American military organizations, and furnished the impetus for the development of professional nursing in the United States. What makes Hanson's article particularly appealing is the emphasis on the establishment of caring networks by female nurses. Through mechanisms such as letter-writing and the use of "lady visitors," communication with women on the homefront became a reality, thus enabling female nurses to "share their mission with women who chose a less active role in the war effort." An important point made by Hanson is that estimates of numbers of female nurses vary widely due to the lack of an agreed-upon definition of "nurse."

Elizabeth M. Norman's fascinating account of military nurses in twentieth-century wars offers a view of the tremendous positive impact of their experiences on peacetime nursing practice. She clearly presents an absorbing account of the technology and information "gathered in tents and Quonset huts" that would ultimately contribute to improved survival rates for injured civilians. Norman, an Associate Professor at Rutgers, the State University of New Jersey College of Nursing, is well known for her writings about nurses in Vietnam and nurses as prisoners of war in World War II. She provides specific examples of techniques and strategies launched during wars that become incorporated within accepted nursing practice. Her thesis that nurses who served overseas during wartime participated in health care advances is well taken as one considers the current use of nurse anesthetists, shock teams, rapid medical evacuation, trauma centers, and triage. Norman concludes that military nurses, as the troops themselves, "had the opportunity to witness and understand extremes in human behavior" in wartime experiences.

Laurie K. Glass, Associate Professor at the University of Wisconsin, Milwaukee School of Nursing, traces the creation and growth of the Naval Reserve Nurse Corps during its first fifty years. The article incorporates the social, political, and environmental factors that shaped the development of the Corps. Glass makes it clear that the Navy Nurse Corps was comprised of both Regular and Reserve factions from the onset and that Reserve nurses could be activated when necessary. The involvement of Reservists in wartime is effectively portrayed as Glass enumerates their many achievements, including the fact that Reservists, not Regulars, were at times the first to serve overseas. Of particular importance is their role during peacetime in both homefront and overseas hospitals and dispensaries. According to Glass, Navy nurses also saw enemy action and were prisoners of war in the Philippines for almost thirty-seven months.

Notes

1. No reference is made to the role of nurses in wartime, for example, in Cynthia E. Harrison, ed., *Women in American History: A Bibliography* (Santa Barbara: ABC-Clio, 1979). Fortunately, numerous publications are becoming available that document firsthand accounts of nurses who served in past wars. See Dan Freedman and Jacqueline Rhoads, eds., *Nurses in Vietnam: The Forgotten Veterans* (Austin: Texas Monthly, 1987); Kathyrn Marshall, *In the Combat Zone: An Oral History of American Women in Vietnam, 1966–1975* (Boston: Little, Brown and Company, 1987); Elizabeth M. Norman, *Women at War: The Story of Fifty Military Nurses Who Served in Vietnam* (Philadelphia: University of Pennsylvania, 1990); Winnie Smith, *American Daughter Gone to War: On the Front Lines with an Army Nurse in Vietnam* (New York: William Morrow and Company, 1992); Gloria R. Leon, "Memories of War: How Vietnam-era Nurses Are Coping Today," *USA Today* 121 (1993): 30–31.

2. E. A. Shields, ed., *Highlights in the History of the Army Nurse Corps* (Washington, D.C.: U.S. Army Center of Military History, 1981), 27.

3. David Ellis and Linda Kramer, "They Also Served," *People Weekly*, May 31, 1993, pp. 90–91.

4. For accounts of Civil War nursing service, see Bonnie Bullough and Vern L. Bullough, *The Emergence of Modern Nursing* (New York: Macmillan Company, 1964), 103, 120.

5. Philip A. Kalisch and Beatrice J. Kalisch, *The Advance of American Nursing*, 2nd ed. (Boston: Little, Brown and Company, 1986), 79; Dan Freedman and Jacqueline Rhoads, eds. *Nurses in Vietnam: the Forgotten Veterans* (Austin:Texas Monthly Press, 1987), 7; Elizabeth A. Leonard, *Yankee Women: Gender Battles in the Civil War* (New York: W.W. Norton & Company, 1994), xvii–xx.

6. The Nurses' Associated Alumnae of the United States and Canada was the second national nursing organization, begun as a confederation of alumnae groups in 1896. It was renamed the American Nurses' Association (ANA) in 1911. The first professional nursing organization—the American Society of Superintendents of Training Schools for Nurses—was established in 1893. It became the National League of Nursing Education (NLNE) in 1912 and merged with the National Organization for Public Health Nursing and the Association of Collegiate Schools of Nursing in 1952 to become the current National League for Nursing (NLN). M. Patricia Donahue, *Nursing: The Finest Art, An Illustrated History* (St. Louis: C. V. Mosby Company, 1985), 360–62.

7. Although the American Red Cross had been founded in 1861 as a constituent of the International Red Cross, its work had chiefly been concerned with emergency relief. No Red Cross nurses were available at the outset of the Spanish-American War. Ibid., 294–96, 327–33; Philip A. Kalisch and Margaret Scobey, "Female Nurses in American Wars," *Armed Forces and Society* 9 (1983): 217.

8. The Nurse Corps became part of the Medical Department of the Army. The name was changed to the Army Nurse Corps (ANC) in 1918. The status of the Army nurse was slow to evolve, however. Army nurses were accorded relative rank in 1920; became eligible for retirement benefits in 1926; and became part of the regular Army with full commission, pay, and other benefits as granted to male officers in 1947. The Navy Nurse Corps was established in 1908. It is

interesting to note that men were not commissioned as nurses until 1955 through the Bolton Amendment to the Army-Navy Nurse Act.

M. Patricia Donahue is a Professor at the University of Iowa College of Nursing in Iowa City. She is the author of numerous articles and chapters related to terminal illness, patients' rights, patient advocacy, and nursing history. Her book *Nursing: The Finest Art, An Illustrated History* received awards from the American Journal of Nursing Company and Sigma Theta Tau International. She is currently working on the second edition of the book.

ACKNOWLEDGMENTS

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A Network of Service: Female Nurses in the Civil War

The American Civil War is often characterized as a peoples' war. It is credited as the impetus for not only the development of professional nursing in the United States but also the emergence of women from the home to larger societal purposes. That feminine perspective has become a topic of considerable interest to historians and the public, but it is elusive and difficult to quantify. Estimates of the number of women who volunteered as nurses vary widely—from one thousand to twenty thousand—largely because there has been no agreed-upon definition of "nurse."

Response to War

Despite the escalation of hostility between the North and South, neither side had planned for the medical realities of armed warfare in 1861. Union and Confederate officials seemed caught up in the rhetoric of a quick and limited war; both focused on the mechanisms for recruiting and training soldiers for a short duration rather than the care those troops would need on the battlefield. No one anticipated a war of attrition—much less an outcome of unconditional surrender. The bureaucratic structure of the United States Army was woefully unprepared; responsibilities for crucial medical services were divided between the Quartermaster Corps (which managed the erection and equipping of hospitals and the transportation of the sick) and the Subsistence Department (which controlled the purchase and transportation of supplies). The Medical Department required the cooperation of both.[1]

Private offers of service followed the firing on Fort Sumter in April 1861. Although there was resistance from the army to such offers, it was clear that charitable groups were the only available solution to growing problems of health and mortality in camps and battlefields. The formation of the United States Sanitary Commission in June consolidated local efforts of the Northern states into a centralized network of philanthropic agencies. The Sanitary Commission had broad powers—to investigate the health and hygienic needs of the largely volunteer army, to raise funds for supplies, and to obtain necessary nursing personnel, possibly women. With the Sanitary Commission, local field agencies became part of a larger organization and could channel

by Kathleen S. Hanson

their efforts more efficiently and directly to the front. Administrative positions in the Sanitary Commission were held by men, but much of the work was done by women.

Southern women also formed local relief societies. Unlike their Northern counterparts, however, the Southern societies lacked a formal coordinating organization that could relate to other public bodies. In addition, Southern relief attempts suffered continuous setbacks from the interruption of drugs and supplies caused by the Union blockade.

Early Recruitment of Nurses

The formation of relief societies was not the only response to the war by American women. Women responded to a perceived need for nursing almost as quickly as men responded to the firing on Fort Sumter and Lincoln's first call for volunteers.[2]

Dorothea Dix, best known as a crusading reformer for charitable institutions, agreed to recruit and superintend female nurses for the Sanitary Commission. The issue was controversial, however, and her original approach was conservative. At first, she attempted to appease her own sensibilities (and those of her critics) by accepting only mature women between the ages of thirty-five and fifty. By 1864, however, the needs were so great that she appointed almost any woman willing to serve. Dix was assisted in her work in the western theater by Mary Livermore, who served with the Western Sanitary Commission. Other women became nurses through state appointments, religious organizations, or merely the simple logistics of being in the right place when a battle occured. Southern and border state women, who were more likely to be nearer an actual battlefield, also responded to the need for nursing, although their efforts were hampered by a more universal acceptance of traditional roles by both men and women.[3]

Few of the nurse volunteers had actual nursing preparation beyond family experiences. Moreover, their duties and status were as diverse as their backgrounds, changing over time as they became more experienced both in nursing and in the politics of working with the all-male Medical Department. That diversity may be an explanation for the wide range of estimates for the number of female nurses who served Union and Confederate troops. Historians Philip and Beatrice Kalisch, for example, set the figure at "close to 10,000"—nine thousand in the North, and one thousand in the South. That figure is comprised of seven categories of service: the 3,214 appointed by Dix who were employees of the army; other women employed by the army temporarily or full-time to perform specific tasks (according to Pension Department Records, about 4,500); several hundred Roman Catholic nuns; women from local or regional private relief organizations; uncompensated volunteers; and an indeterminate number of camp followers.[4]

As the number of categories make obvious, there was no single system for recruiting or preparing the women who responded to the call for nurses. Once in service, the range of activities also varied. Because the available treatments

This Winslow Homer drawing from the September 6, 1862, issue of Harper's Weekly *extolled "Our Women and the War," featuring many aspects of "The Influence of Woman." Pictured are letter-writing, nursing by religious orders, and the contributions of women's relief societies.*

were so limited, the skill of each practitioner could affect the likelihood of decline or recovery. Some female nurses challenged medical treatments or prescriptions of regimental physicians, occasionally saving lives. There was no consensus, even among doctors, on the best way to treat the persistent illnesses of camp life.[5] Female nurses also contributed greatly to care during convalescence, which could be prolonged due to crude battlefield surgeries and amputations.

Service at the Front

In the beginning years of the war, nurses at the front were few in number. The most famous of the front-line nurses was Clara Barton. While adamant that she was prepared for the rigors of the battlefield, Barton was equally sure that few other women were so prepared. Barton preferred to function without female colleagues, isolating herself from Dix's nurses as well as from the Sanitary Commission. She also relied heavily on the personal patronage of powerful men, including Massachusetts Senator Henry Wilson and high-ranking Army officers.[6]

At least one nurse testified to the loneliness and stress of the work. Louisa Maertz, a nurse in a field hospital in Sherman's army at Vicksburg, expressed the following concerns:

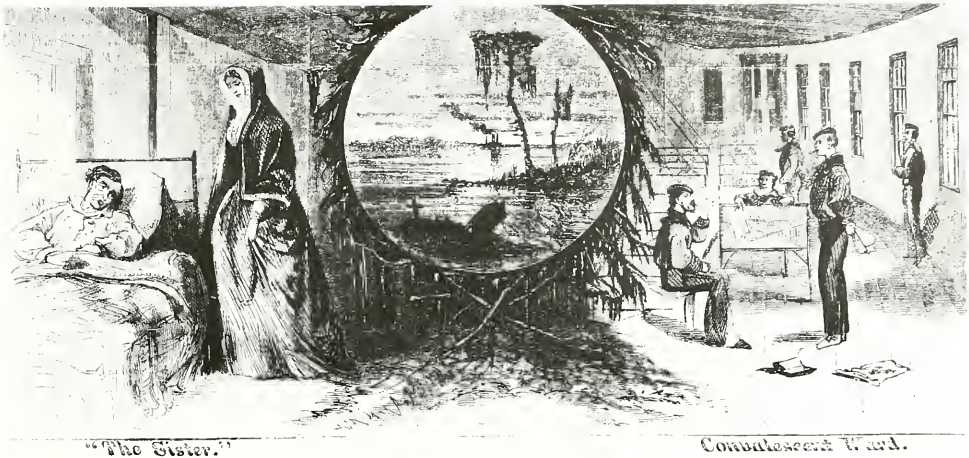
> Had there been any fear in my composition, I could easily have found an excuse for entertaining it. I was apparently the only woman on those hills,—alone—in care of an ambulance driver whose face I had not ever seen. . . . But a woman who fears is no more fit to be a nurse than is a man who fears [is] fit to be a soldier. The presence of Him who commands us neither to fear nor to be dismayed was my safe retreat. I will not say that certain possibilities did not suggest themselves to my mind,—I might even say, were never absent from it; but I do affirm that I neither trembled in terror nor regretted my undertaking.[7]

Battlefield nursing included washing grime and gore from the bodies of the wounded, dressing wounds, and in some instances assisting with surgeries. After major battles it was not uncommon for an injured soldier to be stranded without food for several days. Getting nourishment to such men was critical. Many nurses wrote of their frustration over unsafe conditions as the wounded were transported from battle to field hospital to regimental hospitals. Nurses who served on the hospital ship transport systems during the early Virginia campaigns were especially vociferous in their expressions of outrage over the lack of care.[8]

Official willingness to accept female nurses at the front varied with the intensity of need. The ferocious battles of Wilderness and Spottsylvania in May 1864, for example, resulted in such an incredible volume of wounded that the opposition to women at the front was temporarily lifted. Volunteers joined Sanitary Commission nurses and others to care for the thousands of wounded.[9]

Service at General Hospitals

Well behind the lines, the general hospitals delivered a different level of care. Nursing roles included feeding soldiers; maintaining the cleanliness of the hospital, linens, and when necessary, the



A lonely grave appears on the center panel between the hospital scenes of sick room and convalescent ward of the "Red Rover" hospital ship.

patients; and applying such therapeutic measures as poultices, plasters, and fomentations. Nurses might also administer medicines, including quinine, epsom salts, opiates, whiskey, and calomel. The prolonged convalescence period gave nurses an opportunity to expand their role to the preparation of special diets needed by severely debilitated soldiers and to the supportive care of men facing lives changed by amputation, loss of sight, scarring, and emotional fatigue. Letter-writing became a major tool in helping the invalids bridge the communication of their disability to families and friends. Marilyn Mayer Culpepper's study of such correspondence found that letters served as the very lifeblood of the homefront and camp. Letters to the army on the East coast alone averaged almost forty-five thousand a day![10]

Communication with the Homefront

Letter-writing served another purpose for Civil War nurses, that of arousing and maintaining pressure for the flow of needed supplies from private and charitable groups. Both field hospitals and general hospitals suffered for lack of medicine and other supplies. Female nurses understood how lonely the women at home were and how they longed to hear the details of how their men and boys were living. Women at home wanted to know if their husbands, sons, fathers, or brothers were hungry or if they had warm clothes; were they sick or wounded; and if in the hospital, were they getting better.[11] That information

the female nurses could supply, and if by doing so they could also secure the clothing, food, medicines, and bandages so desperately needed, then the effort of writing was a small task indeed.

As noted earlier, Barton found working within the Sanitary Commission dissatisfying, and she therefore maintained an independent line of communication through her New England family and friends. She corresponded vigorously with ladies' aid societies in her native Massachusetts and New Jersey. Before embarking on her mission with the Army of the Virginia in the summer of 1862, she made a speaking tour across both states urging that supplies for the troops be sent to her for distribution. Barton also made a habit of writing to families of soldiers she had nursed. She let families know if their loved ones had died or, if still living, where they had been taken to be nursed. She provided a woman-to-woman communication link between the soldier on the battlefield and his family at home.[12]

Other women, such as Sarah Gallop Gregg, built networks more gradually. With both a husband and son in the Union Army in 1862, Gregg participated in the Ottawa, Illinois, Ladies' Aid Society. In January of 1863 she visited her husband at the hospitals in Cairo, Illinois. When she realized the scarcity of crucial supplies, she attempted to appeal directly through official channels to the Northwest Sanitary Commission. She addressed her concerns to Mary Livermore, who denied the request because it had not come from an official "detailed nurse." Gregg tersely summed up her feelings in this diary entry: "There seemed to me to be too much red tape about this matter and may God forgive them for no one else will."[13]

Events of the next several days stiffened Gregg's resolve. She observed:

> [T]here is a great need for delicacies for the sick and how am I to get them. . . . [I] arrived today at hospital and a fresh lot of sick and wounded who had been on a steamer for several days without any comforts whatever, lying on the decks without cots or beds and a more pitiful sight I never saw. One man died while being cleansed and dressed and still I had no power to help them.[14]

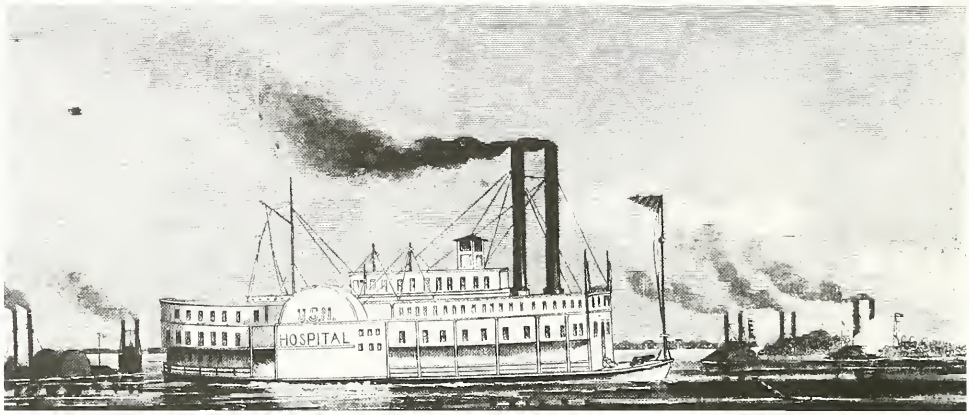
Gregg returned home with a sharpened sense of personal responsibility. During the summer of 1863, when she again experienced problems with sending boxes to the front, she appealed to the nuns in charge of the hospital at Mound City. That direct link between nurses at the hospitals and the homefront was reinforced by a letter of gratitude from the sister in charge of the Mound City hospital.

Gregg later utilized that direct communication pattern during her two years of work as matron of the hospital at Camp Butler, outside Springfield, Illinois. The success of her communication with individuals and local relief organizations was evidenced by a steady stream of incoming supplies. In March of 1864 the neighboring Logan County Aid Society sent relief. Over the next three weeks she received additional equipment (twenty-four chairs) plus a large box of canned fruit and clothing. Throughout Gregg's diary one can find similar entries of letters to aid societies

The noble veteran, disabled by his wounds, is assisted by a nurse in this Harper's *wood engraving titled "Cared For."*

and shortly thereafter the arrival of needed goods.

Another nurse used correspondence as a mechanism to not only gain supplies but also communicate dissatisfaction with an army physician. In autumn of 1861, a Mrs. O. M. Amigh, a nurse with the Third Iowa Regiment, began exchanging letters with Annie Wittenmyer, an agent of the Keokuk Ladies' Aid Society. Amigh's letter of September 1, 1861, provided both a detailed description of equipment sent to the hospital and an emotional plea for assistance: "We have nothing to work with except such things as we have picked up here and there and those things which have been donated."[15] Amigh described available equipment as five mattresses and sheets (items that at home she would have thrown out), five or six "sick shirts," a stack of tin plates, a few towels supplied by herself or sent to a boy who had died, and two pillows and pillowcases—all to meet the needs of twenty-one patients in the hospital and an additional sixty sick



"Red Rover" hospital ship

in the camp! Perhaps Amigh's most pressing reason for writing was to express her dissatisfaction and that of a hospital steward with one of the regimental doctors, Dr. Thomas Edwards, whom she held responsible for failing to secure adequate supplies and equipment. She was hopeful that Wittenmyer would use her influence to have Edwards removed.[16]

Two weeks later, Amigh resumed her report of hospital conditions and her ongoing conflict with Dr. Edwards. She also overtly hinted that she would be appreciative of any supplies Wittenmyer might have already sent.[17] Her correspondence was effective, as she noted soon after: "I received a letter from you the day before yesterday in the morning, at night I received the package of things of which you wrote, and found it much larger than I had expected. I know not how to thank you and your assistants for the comforts contained in the package. I can only say for myself and in behalf of the sick ones, God bless you all. You can never realize how much they add to the welfare of the sufferers here."[18] She also hinted at the politics within the Third Iowa that prevented officers from demanding Edwards's discharge.

Weeks later she again thanked Wittenmyer for her support and renewed her complaints against Edwards.[19] Amigh, like many of the female nurses, was sensitive to the quality of regimental physicians treating soldiers. It was clear that she worked smoothly with most of them, including a Dr. Cool, who successfully intervened to improve the flow of supplies when Edwards failed to do so.[20]

Role of "Lady Visitors"

Female nurses were not the only feminine presence at Civil War hospitals. "Lady visitors" were all too common. The reactions of soldiers, physicians,

and nurses to visitors were mixed. Many considered them to be an annoyance of the greatest degree. Several nurses complained bitterly about the "do gooders," especially if they moved beyond the role of visitor and attempted to take on activities better handled by trained nurses. The contempt of the nurses may also have been generated by a difference in perspective. Female nurses had placed themselves in a precarious social position by taking on the nursing role, and by doing so had made a genuine commitment to the war effort. Lady visitors, on the other hand, remained in a socially accepted role and could "float" in and out of the war effort as it pleased them.[21]

Despite those occasional feelings of distrust, all visitors were a potential source of support. Sarah Gregg capitalized on their presence to the benefit of her patients. Throughout her diary she recorded the names of lady visitors and their suggestions for improving the welfare of soldiers. Gregg cultivated a close relationship with the Springfield Ladies' Aid Society, for example, and she invited its members to visit and see for themselves how important their donations were. She offered the same firsthand opportunity to other visitors. The success was immediate; contributions were received from Lincoln, Decatur, Jacksonville, and other towns throughout central Illinois.[22]

Nurses also cultivated friendships with their colleagues in other hospitals, as shown by the number of nurses and hospital matrons who visited Gregg at Camp Butler.[23] On a return trip from Vicksburg, Gregg had an opportunity to visit with Mary Ann Bickerdyke at the Gaosee Hospital in Memphis.[24]

Mary Ann Bickerdyke

One can imagine that these visits included a sharing of experiences and requests for assistance, because later correspondence shows a sensitive concern for each others' problems.

Bickerdyke, in turn, corresponded with Wittenmyer, who by 1865 had joined the United States Christian Commission

and was in charge of establishing special diet kitchens for soldiers. Bickerdyke asked Wittenmyer's assistance for a similar facility for Camp Butler, where a former colleague, a Mrs. Green, was a nurse. Bickerdyke and Green had served together at Corinth and Memphis.[25] Apparently, the two had stayed in communication, for Bickerdyke was willing to share her influence to help her fellow nurse. Such fragments of evidence suggest that it was not unusual for female nurses, at least in the western theater, to be in communication with each other regarding work and needs.

Women nurses participated in an unprecedented number of activities related to the care of wounded and sick soldiers during the Civil War. Using communication skills, they sought to ensure the quick passage of supplies and nursing personnel. They established networks of communication between each other and women on the homefront. Letter-writing and firsthand observations were deliberate tools in that network. Whether those channels included such official entities as the Sanitary Commission or simply a network of associates and friends (as Barton preferred), the lines of communication were essential to the success of nurses who provided front-line care.

Amigh and other nurses who served in ill-equipped regimental hospitals found communication with the homefront the only reliable method of procuring even the most basic needs in those networks. Gregg and others who volunteered in convalescent hospitals took advantage of both letter-writing and the good will of "lady visitors" to build larger networks of support. Those caring networks allowed female nurses to share their mission with women who chose a less active role in the war effort. Throughout the Civil War, the contributions of women in organizing relief agencies and serving as nurses changed forever the concept of women's roles—at the front and at home—and planted the seeds for the inclusion of trained women nurses in American military organizations.

Notes

1. George Worthington Adams notes that by January, 1861, the United States Army had grown from 13,531 to 16,000 soldiers and the Medical Department had decreased from 113 officers (30 surgeons and 83 assistants) to only 98; Adams, *Doctors in Blue: The Medical History of the Union Army in the Civil War* (Dayton, Ohio: Press of Morningside, 1985), 3–5.

2. For responses of early nurse volunteers, see Quincealea Brunk, "Caring without Politics: Lessons from the First Nurses of the North and South," *Nursing History Review* 2 (1994): 120–36.

3. More detailed discussion of Confederate relief societies and the role of Southern women as nurses can be found in United Confederate Veterans, Arkansas Division, *Confederate Women of Arkansas in the Civil War, 1861–'65: Memorial Reminiscences* (Little Rock: H. G. Pugh Printing Company, 1907); Kate Cumming, *A Journal of Hospital*

Life in the Confederate Army of Tennessee (Louisville: John P. Morgan, 1866); Mary Denis Maher, *To Bind Up the Wounds: Catholic Sister Nurses in the U.S. Civil War* (New York: Greenwood, 1989); and Mary Elizabeth Massey, *Ersatz in the Confederacy* (Columbia: University of South Carolina Press, 1952).

4. Philip A. Kalisch and Beatrice J. Kalisch, *The Advance of American Nursing*, 2nd ed. (Boston: Little, Brown and Company, 1986), 79. For explanations of estimates as high as 20,000, see Elizabeth D. Leonard, *Yankee Women: Gender Battles in the Civil War* (New York: W. W. Norton, 1994), xvii–xx, and Jane E. Schultz, "The Inhospitable Hospital: Gender and Professionalism in Civil War Medicine," *Signs* 17 (Winter 1992): 363.

5. Both Sophronia E. Bucklin and Mary A. Newcomb came into open conflict with surgeons whom they felt were too quick to amputate. See Bucklin, *In Hospital and Camp: A Woman's Record of Thrilling Incidents among the Wounded in the Late War* (Philadelphia: John E. Potter & Co., 1869), 108–9, and Newcomb, *Four Years of Personal Reminiscences of the War* (Chicago: H. S. Mills & Co., 1893), 33–36.

6. Clara Barton agonized over the dilemma of believing the battlefront was the most appropriate place for her to be and the fear of social criticism for defying the accepted standards for women's behavior. Although her father's approval for a battlefront role freed her from that dilemma, her actions with women assistants later in the war indicate that she did not believe other women should be present at the front. She took no other woman with her as she followed McClellan's army in September of 1862. In the summer of 1863, during the siege of Fort Wagner, she determined conditions to be so difficult that she sent Mary Gage, an assistant, back to Hilton Head. Barton remained on Morris Island. Stephen B. Oates, *A Woman of Valor: Clara Barton and the Civil War* (New York: Free Press, 1994); Elizabeth Brown Pryor, *Clara Barton: Professional Angel* (Philadelphia: University of Pennsylvania Press, 1987).

7. Louisa Maertz, "*Midland* War Sketches IV: Extracts from the Home Letters of One of Miss Dix's Nurses in 1863—A Lone Woman's Journey to Her Post within the Lines," *Midland Monthly*, Jan. 1895, p. 81.

8. Descriptions of transporting wounded soldiers from field hospitals to general hospitals can be found in Sarah Gallop Gregg, "Diary," TS, Illinois State Historical Library, Springfield; Cornelia Hancock, *South After Gettysburg: Letters of Cornelia Hancock, 1863–1868*, ed. Henrietta Stratton Jaquette (New York: Thomas Y. Crowell Company, 1956); Paul H. Hass, ed., "A Volunteer Nurse in the Civil War: The Letters of Harriet Douglas Whetten," *Wisconsin Magazine of History* 48 (Winter 1964): 131–51; Katharine Prescott Wormeley, *The Other Side of the War: With the Army of the Potomac* (Boston: Ticknor & Co., 1889); Annie Turner Wittenmyer, *Under the Guns: A Woman's Reminiscences of the Civil War* (Boston: E. B. Stillings & Co., 1895).

9. Oates, *Woman of Valor*, 230–40; Linus Pierpont Brockett and Mary C. Vaughan, *Woman's Work in the Civil War: A Record of Heroism, Patriotism, and Patience* (Philadelphia: Zeigler, McCurdy & Company, 1867); Anna Holstein, *Three Years in Field Hospitals of the Army of the Potomac* (Philadelphia: J. B. Lippincott & Company, 1867); Mary Holland, *Our Army Nurses. Noble Women Who Served in Hospitals and on Battlefields During Our Civil War* (Boston: B. Wilkins & Company, 1895).

10. Marilyn Mayer Culpepper, *Trials and Triumphs: The Women of the American Civil War* (East Lansing: Michigan State University Press, 1991), 281.

11. Culpepper, *Trials and Triumphs*, 281–90.

12. For recent, well-documented biographies of Barton and her Civil War activities, see Oates, *A Woman of Valor;* and Pryor, *Clara Barton.*

13. Gregg, "Diary," Jan. 17, 1863.

14. Ibid., Jan. 18 and 20, 1863.

15. Mrs. O. M. Amigh to Annie Wittenmyer, Sept. 1, 1861, War Correspondence of Annie Wittenmyer, 1861–1865, Box 1, Folder 2, Iowa State Historical Library, Des Moines (all Wittenmyer correspondence is from that collection).

16. Ibid. Amigh does not fully explain the reasons for her dislike of Edwards but hints that she blamed him for the lack of supplies. Apparently she feared that disclosing her enmity toward Edwards might have repercussions, as evidenced by her request to Wittenmyer to keep her name and the steward's name in trust.

17. Amigh to Wittenmyer, Sept. 15, 1861.

18. Amigh to Wittenmyer, Sept. 28, 1861.

19. Amigh to Wittenmyer, Nov. 1, 1861. Amigh confirms that she held Edwards responsible for failing to secure adequate supplies and equipment. The second regimental doctor, a Dr. Cool, intervened and the needed supplies and equipment arrived. She also hints at the politics within the Third Iowa that prevented officers from demanding Edwards's discharge. It is not known if Wittenmyer participated in the solution of the physician problem.

20. For additional information regarding the relationships between female nurses and the doctors, see Leonard, *Yankee Women,* 30–36.

21. Ibid., 42.

22. Gregg, "Diary," Mar. 15, May 14, Aug. 23, 1864, and Jan. 1, 1865.

23. Ibid., Feb. 25, March 11, 1864.

24. Ibid., June 17, 1863.

25. Bickerdyke to Wittenmyer, Feb. 24, 1865.

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American Military Nurses in Wartime and the Impact of Their Experiences on Peacetime Nursing Practice

by Elizabeth M. Norman

Nurses who served and lived through wars changed. They seldom viewed life from the narrow confines of home or the local hospital. They returned stateside with new technological and administrative skills sharpened by working with battle casualties. This paper will describe the experiences of American military nurses in twentieth-century wars and interpret the enduring changes those war experiences imposed on peacetime nursing.

On February 2, 1901, Congress established the Nurse Corps (female) as a permanent corps in the Army Medical Department. Members held no formal rank, however. They received appointments rather than commissions, and they were not eligible for retirement or veterans' benefits. Their salaries were below that of civilian nurses. Seven years later, on May 13, 1908, the Navy established its own Nurse Corps with the same pay and rank restrictions as the Army.

World War I recruiting poster from the Red Cross on behalf of the Nurse Corps of the Army and Navy

World War I

World War I jolted the Western world out of the formal Victorian era. Along with the young men who entered the ambulance corps, many young women entered the respected profession of nursing as a way of leaving home and supporting themselves. "I didn't want to marry a farm boy," said Mina Aason, a farmer's daughter from Minot, North Dakota, who entered Columbus Hospital

Posters such as these appealed to the patriotic sentiments of America's trained nurses at the outbreak of World War I.

School of Nursing at Great Falls, Montana, in 1916.[1]

In that year, the United States was continuing its official policy of neutrality, but many American women had gone overseas as Red Cross nurses. In humanitarian response to the horrors of trench warfare and the unprecedented use of mustard gas, these and other volunteers of the British Expeditionary Force became the trauma experts of their day in a baptism of horror.

Modern artillery fire, poison gas, fragmentation shells, and steel-jacketed bullets produced never-before-seen wounds. Gas gangrene, the scourge of foot soldiers, frequently occurred because armies fought battles on farmland contaminated with animal feces. Nurses filled Carrel-Dakin devices with hypertonic saline or with weak antiseptic solutions containing gentian violet or acriflavine. The solution traveled through perforated rubber tubes and irrigated the infected wound. Physicians used x-ray machines to find shell fragments.

Mustard gas, which penetrated clothing, burned skin, and irritated eyes and lungs, produced more casualties among the Allies than all weapons. The heart-

breaking memories of caring for those men remained vivid to nurses for years. They never got used to the suffering they saw. In later wars, their successors felt the same way about caring for men blasted by flame throwers or burned with phosphorous and napalm.

Nurses washed poison gas victims with a bleach ointment and bathed contaminated skin in a two percent sodium bicarbonate solution. Fear of enemy gas attacks remained strong through all later conflicts.

After the American declaration of war on April 6, 1917, the Army and Navy nursing corps grew dramatically—the Navy Nurse Corps from 466 members in 1917 to 1,386 in 1918, and the Army Nurse Corps from 403 to 21,480. Of those, ten thousand were either serving in or en route to the war zone. The earliest group of Army nurses sailed to Europe in May 1917, to join the British Expeditionary Forces and the many American nurses already serving in the Red Cross. On the wards, the nurse-patient ratio could reach 1:50.

American nurses encountered new and horrifying conditions in their patients, including the battlefield shock induced by modern warfare. Their instructions were basic and common sense: "Resuscitation should be prepared and organized. The patients are made comfortable in beds if possible, they are kept quiet, reassured and given morphia if necessary. 'Réchauffment' is carried out by electric cradles, hot water bottles, improvised hot-air stoves, etc. . . . Fluids must be given . . . simple drinks or warm sweet tea will be sufficient in many cases. If the patient is unconscious, attempts should be made to give glucose saline per rectum."[2]

The pressures and rewards of early trauma nurses were related in the letters of Mary Christy, a 1905 graduate of Passavant Nursing School of Chicago, who had set out for France soon after the American declaration of war. Because caring for young wounded soldiers was so stressful, Christy coped by focusing her attentions on her immediate workload. She and her fellow nurses could not attend to all the suffering around them and still fulfill each patient's needs. A letter written in August 1917, from No. 18 General Hospital, British Expeditionary Force, France, captured the drama of her situation.

> This is a surgical war and the poor fellows are shot to pieces. Some of them have pieces of shrapnel in them all over from head to foot. I have some who are rather noisy at night, just now. They get nightmares. I sure hope the awful war will soon cease before our own American boys get shot to pieces and maimed for life as so many of these poor lads are. You can't stand it to stop and think about things; the best is to go on and keep a stiff upper lip and do what you can—and there is always plenty to be done.[3]

Fifty-two years later, an Army nurse at the Eighty-fifth Surgical Hospital in Phu Bai, South Vietnam, described a similar bravery when she wrote: "You never cried while you were on duty because if you cried everyone in the whole room would lose it. There was such tremendous sorrow and you had a job that had to be done."[4]

World War I nurses also experienced the devastating influenza pandemic of

Mary Christy's World War I service was in France, through the height of the influenza pandemic.

1918–1919, which took a great toll not only on combatants but on the personnel who nursed them. The only available defenses against the spread of flu were masks, gloves, and thorough handwashing—the same techniques used in infection control today. For Christy, the announcement of an Armistice on November 17, 1918, was overshadowed by influenza losses. She wrote:

> I have just passed one the hardest weeks I have had since I've been over here. Last Monday the chief nurse called me to come over and see Jeanette. I found her very very bad. That evening just as everybody was shouting peace and were so happy that the armistice had been signed she sank into unconsciousness and died. She was buried Monday morning in the little American cemetery near the hospital beside two other nurses who had given their lives in the same way.[5]

Altogether, 101 American nurses never came home. Most deaths were attributable to complications from influenza and other diseases. Two were from what veterans in later wars would call "friendly fire."[6] Helen Wood and Edith Ayres, while en route to Europe, were fatally wounded by brass fragments from the faulty discharge of a gun. At least three casualties resulted from enemy air raids.

The enduring, sad legacy of these brave women is visible in the nurses' section of Arlington National Cemetery, where a statue memorializes Jane Delano, who served as superintendent of the Army Nurse Corps and chairman of the Red Cross Nursing Service. Delano died in France on April 15, 1919, at an Army hospital. She was on an official visit for the Red Cross when she developed a brain abscess from an ear infection and died.

Several lasting professional changes emerged from the First World War. Trained professional military nurses—all graduates from schools of nursing—were available for the first time. Also for the first time, nurse anesthetists assisted in military surgical suites. The concept of employing shock teams and rapid medical evacuation from small front-line hospitals to larger facilities away from the fighting took hold. Smaller units of doctors, nurses, and assistants near the front line proved to be an effective way of saving lives.

In World War I, 50,280 American men were killed in battle and 62,000 died of disease. Most medical deaths were from the influenza pandemic of 1918–1919.

World War II

Nurses were present at Pearl Harbor when the Japanese attack began World War II. The same day Army nurses in Baguio and Fort Stotsenberg, Philippines, endured their first Japanese attacks. The suddenness of the bombardments and the public's naiveté resulted in many initial injuries from running to windows or front lawns to look at the aircraft. During those early assaults, nurses employed a crude form of triage in the wards. They crawled among the wounded with a large syringe filled with morphine. After injecting a patient, they marked an "M" on the forehead with lipstick or mercurochrome in order to indicate who had received analgesia and who had not. Once the staff identified the living from the dead, the nurses

Navy Nurse Corps stationed at Fleet Hospital 103, Guam, 1945

tagged each patient for treatment needed—"Immediate Surgery," "Major Surgery," "Minor Surgery."

On Bataan and Corregidor, Philippines, Army nurses suffered through some of the war's worst battles. Eleven Navy nurses and sixty-seven Army nurses were captured by the Japanese during five months of fighting. They survived thirty-seven months as prisoners of war and earned the distinction of being the largest group of women POWs in American history. Throughout their ordeal they never stopped working, and many credited their ability to remain practicing as nurses as essential to their survival. As long as patients needed them, they had a reason to continue to struggle. As one recalled: "Nursing was part of our salvation; we were still able to be nurses; we continued to do what we were trained to do. The more we had to think of somebody else and their problems and care for them, the less time we had to cry."[7]

Five Navy nurses captured on Guam in December 1941 were taken to Japan but released eight months later as part of a POW exchange. Six American nurses died on the Anzio beach in Italy in 1943 after enemy shells hit an evacuation hospital.

Faced with the need to evacuate casualties from the Pacific Islands and European battle zones, the military established the new specialty of flight nursing. Lucy Wilson, who escaped from Corregidor but returned to the Pacific as a flight nurse, wrote of her time with the 801st Medical Air Evacuation Squadron,

"We sometimes had to circle the landing strips until firing ceased so we could land and quickly unload supplies and then load patients to fly back."[8]

Wounded men benefited from recent scientific discoveries. Nurses administered new stimulant and narcotic drugs. They checked patients receiving blood plasma and a variety of intravenous fluids. Penicillin, first of the wartime miracle drugs, saved many lives. Those treatments and more-rapid evacuation contributed to a 96 percent survival rate among the wounded.

As the war progressed, the number of military nurses rose to more than 76,000.

Korea

By 1950, as world tensions increased to produce the Korean conflict, flight nurses had become permanent members of the U.S. Air Force. Compared with previous American wars, the number of nurses serving overseas was small. About five hundred Army nurses went to Korea, while dozens of Navy nurses lived and worked on three hospital ships. Despite that small number, the war had a strong impact on nursing practice.

Helicopters transported the wounded to mobile units, where a steady blood supply, greater varieties of antibiotics, and new life-support equipment (including respirators) were available to manage casualties. New technologies improved so much that mortality rates fell to half of those in World War II. At the same time, military nurses had to become more proficient with technology. The survival of patients who would have died in earlier wars not only placed new emphasis on rehabilitation but also raised ethical questions about who could or should be saved. Critical care nursing practice emerged as a specialty.

Vietnam

From 1965 through 1973, the daughters of World War II and Korean veterans returned to the Pacific to care for soldiers in Vietnam. Experts estimate that eight thousand of the more than eleven thousand women who served in Vietnam were military nurses.

Their motives, like their mothers', were patriotic. "How could I say, 'Oh no, not me,' when men my age were going," said on veteran nurse, "I really felt, 'how come *not* me?'"[9]

Army nurses saw service at large acute-care hospitals, convalescent facilities, smaller evacuation hospitals, and surgical units. Navy nurses served at two land facilities as well as on two hospital ships, *U.S.S. Sanctuary* and *U.S.S. Repose*. Air Force nurses based at three major airfields in South Vietnam ferried casualties from Vietnam to Japan, Okinawa, and the United States. A few military nurses worked in provincial hospitals.

Vietnam nursing benefited from the rapid evacuation system perfected during World War II and Korea. Dozens of casualties from the battlefield could arrive at hospital receiving wards (emergency rooms) within minutes of injury. One nurse remembered looking at a patient's shattered wristwatch as she prepared him for surgery. The watch had stopped seventeen minutes earlier, the moment he was wounded. That rapid evacuation system became the

First Lieutenant Sharon Cook, medical crew director and member of the Air Force Nurse Corps, checks Army casualties being evacuated from Tan Son Nhut, Vietnam.

prototype for the current flight teams working in trauma today.

Military nurses served the same one-year tour as men. They also experienced the political and military ebb and flow of American support for the war. Personnel and casualties in Vietnam were younger than those of earlier wars. Nurses often remarked that patients reminded them of younger brothers or neighbors. The average age of military nurses was twenty-three years old, and the average age of enlisted men was nineteen.

In Vietnam, nurses worked the same long hours performing treatments, administering medications, and soothing fears that their predecessors did. And like earlier nurses, most women had one patient and one moment they clearly remembered. For example, one Air Force nurse spent months flying patients from battlefields to hospitals throughout South Vietnam. Each day medics carried dozens of wounded soldiers through the aircraft doors on bloodied ponchos or litters. The first thing she did was to check the snugness of dressings in order to make sure that no one had hemorrhaged during the short flights. Most of her conscious patients laid quietly. She joked with them, held their hands, and checked their vital signs. One day, however, her humor left her:

> As the plane lifted off, I pulled back the covers on this guy to see if he was bleeding. He had an AK [above the knee] amputation of the right leg. Between his left leg and the amputation was a Purple Heart. He reached down and picked it up. He was so proud of it. "Isn't it neat?" he told me, "A general gave this to me." I'm standing there looking at this kid and I wanted to cry.[10]

That story also illustrates another universal aspect of wartime nursing—no one knows war better than those who tend its casualties. Soldiers are too preoccupied with the business of fighting and dying to keep track of the awful inventory of battle; only years later does the scope of the slaughter really begin to stagger them. Those who stand over the gurneys and the beds know war like no one else.

When the sound of the helicopters was stronger and louder than usual, experienced nurses knew a mass casualty situation was about to happen. Large numbers, sometimes 150 patients in two hours, arrived for treatment. The workday expanded to twenty-four hours, thirty-six, or more. Nurses stationed in Vietnam during the 1968 Tet Offensive and Counteroffensive regularly experienced such situations.

Mass casualties were not unique to Vietnam, but the efficiency of the evacuation and treatment systems served as models for peacetime trauma centers. Specialty practice in trauma gained wider acceptance. Data from Vietnam on monitoring technology, fluid resuscitation, Adult Respiratory Distress Syndrome (once called DaNang Lung), and blunt and penetrating injury management vastly improved trauma treatment at home.

Triage

A different triage priority also emerged from the mass casualties of

Vietnam. While an experienced surgeon assumed overall responsibility, nurses would determine the order or priority in which patients would go into the operating rooms. In Vietnam, the least injured patients—i.e., those requiring the least amount of the surgeon's time—were taken first.

Patients with head injuries might require six hours of valuable operating room time, while surgeons could operate on ten patients with lesser needs during the same six hours. Thus, patients with serious head injuries went to the back of the line; most survived the waiting period, but some did not. The triage method was practical and necessary, but unsettling for nurses. They often checked waiting patients as they went about their work. That triage policy and nurses' adaptation to it is similar to the current "limited resource" questions being debating in modern health care.

Patients who had no chance of survival were placed behind screens in the corner of receiving wards or intensive care units. So many other patients needed immediate care that there was no time to spare for the hopeless. For the nurses, it was crucial that such soldiers not die alone or unattended. The would touch them and whisper in their ears. The care and needs of these expectant patients are similar to today's non-military patients with "Do Not Resuscitate" orders.

Vietnam veterans brought the identification and treatment of Post-Traumatic Stress Disorder (PTSD) into mainstream psychiatric practice. A stereotype of nurses suggests that they were harder and tougher than others. The public believed that their training and their exposure to pain, sickness, and death protected them from mental strain. Vietnam nurse-veterans were the first group of women to admit that they too could suffer from wartime experiences. They demanded and eventually received the right to be treated in the Veterans Administration system for PTSD.

Persian Gulf War

The Persian Gulf War of 1992 did not last long enough to bring about the kind of technological or methodological adjustments for military nurses that previous wars of the twentieth century had. The impact from the Persian Gulf will most likely address the professional issues of single parenthood, responsibilities of mothers, and activation of reservists.

Also, the Army is collecting and analyzing data from nurses relevant to the unique stresses of the Desert Storm experience.

Conclusion

Just as war has always been a crucible for men, so it has been in the twentieth century for military nurses, who have had the opportunity to witness and understand extremes in human behavior. Each nurse saw both courage and selflessness, cruelty and cowardice. They came to know fear and vulnerability—not just in their patients but in themselves as well. They discovered their own weaknesses and inadequacies. In short, they found that they were human. Nurses, like many of their fellow soldiers, came home with a knowledge that they had survived the worst of life's

experiences. "Nothing," recalled an Army nurse who now lives in rural New Jersey, "can ever be the same after you've been in that environment."[11]

Wartime nursing had a tremendous positive impact on peacetime practice. Many injured civilians lived because of the technology and information gathered in tents and quonset huts. Women who served overseas participated in those health care advances. In so doing, they not only saved the lives of American volunteers but also aided in the progress of American health care.

Notes

1. Gladys E. Bruhn, *Memories of Mina* (Minot, N.D.: Gladys E. Bruhn, 1982), 2.

2. P. H. Mitchiner and E. P. MacManus, *Nursing in Time of War* (London: Churchill, Ltd., 1943), 80.

3. Mary Christy Collection, Midwest Nursing History Resource Center, University of Illinois, College of Nursing, Chicago.

4. Anonymous Vietnam veteran, Army Nurse Corps, tape-recorded interview by author, Philadelphia, Nov. 2, 1984. "Women at War" study. All subjects interviewed for that 1984 project were given anonymity. Tapes are on deposit with the author.

5. Mary Christy Collection.

6. Lynda VanDevanter, *Home Before Morning: The Story of an Army Nurse in Vietnam* (New York: Beaufort Books, 1983), 319.

7. Helen Cassiani Nestor, interview by author, Norristown, Pa., Dec. 10, 1990.

8. L. Wilson Jopling, *Warrior in White* (San Antonio: Watercress Press, 1990), 78.

9. Anonymous Vietnam veteran, Army Nurse Corps, interview by author, East Orange, N.J., May 31, 1984.

10. Anonymous Vietnam veteran, Air Force Nurse Corps, interview by author, McGuire Air Force Base, N.J., July 16, 1984.

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The Naval Reserve Nurse Corps: The First Fifty Years, 1908–1958

The creation and growth of the Naval Reserve Nurse Corps emerged from a unique set of social, political, and environmental factors. Its history intertwines with that of the Navy Nurse Corps, military nursing, women in American society, professional nursing, the Red Cross, and many other areas. Through most of the first half of the twentieth century, nurses were the only women serving in the United States Navy. They found that breaking new ground was not always a positive experience. As late as twenty years after the establishment of the corps, Superintendent Josephine Beatrice Bowman still found some resistance among military doctors to "petticoat government" in Navy hospitals.[1]

Nineteenth-Century Roots

Nursing in the Navy was originally carried out by members of the ship's crew appointed to assist the surgeon and his mate. Men who performed nursing duties were given no training, however, nor did they have any special status until establishment of the Hospital Corps on June 17, 1898, during the Spanish-American War. Also during that period, the first trained female nurses were hired at the Naval Hospital in Norfolk, Virginia. Those nurses were hired for only fifty days. Their formal status was questionable, but they were eventually paid when means were found for their reimbursement.[2]

Because of the creation of an Army Nurse Corps (female) in 1901, there was great interest in the Medical Department of the Navy to formalize a nurse corps. Without success, the Bureau of Medicine and Surgery (BUMED) advocated legislation in 1902 and 1904.[3] In 1907 Surgeon General P. M. Rixey emphatically stated that the lack of skilled nursing was "the most serious omission" in the Navy medical system:

> That women nurses are by natural endowment and special aptitude superior to male nurses for much of the duty required . . . is generally admitted; that their employment is compatible and would not conflict with the conditions arising from the military character of our institutions may be inferred from the experience of the Army, which acknowledges their work as deserving of the warmest praise.

by Laurie K. Glass

The views presented here are those of the author and do not represent the United States Navy.

Josephine Beatrice Bowman, who served as Superintendent of the Navy Nurse Corps from 1922 to 1935. Visible on her left shoulder is the Nurse Corps pin.

> . . . Moreover, in addition to supplying more efficient medical and surgical nursing than is now obtainable, valuable services could be rendered by the trained women nurses in teaching the men of the Hospital Corps their special duties in caring for the sick. . . . [T]he lack of proper nursing means greater suffering.[4]

Not until May 13, 1908, was the Nurse Corps (female) of the United States Navy established by law. Its actual status, in the words of Naval historians, was "unique." Navy nurses were "officially recognized as members of the Naval service and amenable to military discipline" but held a "quasi-military classification which could not be designated as either commissioned or enlisted status." The bill made no provisions for retirement or pensions. The bill authorized the appointment of as many chief nurses, nurses, and reserve nurses as needed. Reserve nurses could be assigned to active duty "when the necessities of the service demand" and would receive the same pay and allowances of Regular Navy nurses when on duty.[5] Thus, from the start, the Navy Nurse Corps was comprised of both Regular and Reserve factions. As needs grew or waned throughout the twentieth century, the numbers of each fluctuated widely, with Reserves usually outnumbering Regulars.

The Corps in 1908

Appointed as first "Superintendent" was Esther Voorhees Hasson, a veteran Army nurse who had served on the hospital ship *Relief* during the Spanish-American War. Her annual salary was set at $1,800. Names of the original fifteen members of the Nurse Corps (female) were published in the November, 1908, issue of the *American Journal of Nursing*. Five, like Hasson, had been Army nurses. These original nurses were assigned to the Naval Medical School Hospital at Washington, D.C.[6]

To be eligible for appointment, nurses had to be graduates of an approved two-year general hospital school of nursing and had to meet the standards of their state, if any, for registration. (Since registration had begun in 1903, few states had such requirements by 1908.) Candidates had to be unmarried, of good moral character as certified by their school, and capable of passing the physical and mental examinations administered by the Navy. Written and oral tests covered general nursing, surgical nursing, first aid, dietetics, materia medica, and toxicology.[7]

Beginning Navy nurses were paid $50 a month ($600 per year), plus 75 cents per day for subsistence and $15 per month for housing; chief nurses received an additional $30 per month. Since no military quarters were provided for them, the Navy nurses rented two houses and managed their own mess (dining facilities). An official uniform and cap were prescribed.

Upon successful completion of a six-month probation period, nurses received "the special insignia of the corps," a gold-plate pin the size of a quarter, which had a dull rough surface. An anchor combined with a caduceus and the letters "U.S.N." appeared in blue enamel beneath the design.[8]

First home of Navy Nurses at 539–541 Twenty-first St., NW, Washington, D.C., in 1908

Navy nurses had to agree to serve three years. Their duties included receiving report, putting the ward in order, seeing that orders were carried out, instructing hospital apprentices (corpsman) in practical nursing and care of the sick, and monitoring charts, requisitions, and treatment books. The working conditions were quite favorable: In peacetime, Navy nurses worked eight-hour shifts. They were not expected to work the night shift for more than a month, nor more often than one out of every three months. In large naval hospitals, operating room nurses, diet nurses, and linen room nurses were exempt from night duty altogether.

Navy nurses charted new territory. Not only did they have to deal with nursing for the government under newly established rules and regulations, but they entered an all-male world, or—according to Bowman—"what man calls his domain." Over time, as Bowman elaborated, even those who opposed women in the Navy became converted when they required medical care:

> Paradoxical as it may sound, men are men when strong and healthy, but when sick, they are not men but patients. As few were immune to sickness or injury, the number of patients who reverted to type and became men again, carried quite a different feeling for women, that is, nurses, in the Navy. The knockers became the boosters and Father Time did the rest.[9]

If the services of graduating Navy nurses were not immediately needed, they were put on the "eligible [or reserve] list."[10] Navy nurses could also, after six months, seek an honorable discharge and request to be transferred to that "Reserve Nurse" list, where they could remain until the age of forty-five. Reserve nurses were "expected to respond to calls for active service with reasonable promptness."[11] They were entitled to wear the device of the Nurse Corps but did not receive any other privileges. They were responsible for keeping BUMED advised of address changes. A nurse could be dropped from the Reserve list for medical reasons, failure to respond to a call, or interruption of practice for five years.

Expansionary Years

In 1909 the corps extended its services to hospitals in Annapolis, Maryland, and New York. In addition to chief nurses for those facilities, the total number of Navy nurses doubled to forty. Chief nurses served as director of nursing at each hospital. Their work was especially appreciated in the training of Hospital Corpsmen, the young men who assisted the Medical Corps on board ship, many of whom had "the natural disinclination of the male for nursing."[12]

Superintendent Hasson predicted in 1909:

> One of the principal duties of the woman nurse in the Navy will be the bedside instruction of the hospital apprentices in the practical essentials of nursing, and for this reason she must be thoroughly conversant with the head nurse routine of a ward. When treatments, baths, or medication come due it is not expected or desired that she will always give these herself, but it will be her duty to see that the apprentices attached to the ward carry

out the orders promptly and intelligently. This arrangement does not, however, absolve the nurse in any way from doing the actual nursing work whenever necessary, but is in a line with the general principle instilled into her from first to last, and which she is expected to always keep uppermost in her mind. I mean the improvement of the apprentices to whom the bulk of the nursing of the Navy afloat will always fall, for it is not the intention of the Surgeon General to station women nurses on any but hospital ships.[13]

As the European War threatened in 1914 and America was vowing neutrality, it was left to the Red Cross, not the Army or Navy, to actively recruit and process nurses for disasters or military emergencies. Lenah Sutcliffe Higbee (who succeeded Hasson as superintendent in 1911) described the process in an article for the *American Journal of Nursing*, reminding her readers that the Red Cross acted as a reserve for both the Army and the Navy.[14]

In 1916, Congress established the U.S. Naval Reserve Force (USNRF), which was composed of six categories. While nurses were not specifically mentioned, they nevertheless met the criteria to serve in two of the six categories. When the United States entered World War I on April 6, 1917, there were a total of only 160 Navy nurses; that number grew dramatically over the ensuing months, mostly from Reserves who were recruited through the Red Cross. By September, Reserves outnumbered Regulars by more than two to one. The implications of such an increase, as well as the changes that would occur through creation of the USNRF, were discussed in

Superintendents and Directors of the United States Navy Nurse Corps

1908–1911	Esther Voorhees Hasson
1911–1922	Lenah Sutcliffe Higbee
1922–1935	J. Beatrice Bowman
1935–1938	Myn M. Hoffman
1938–1939	Virginia A. Rau *Acting Superintendent*
1939–1946	Sue S. Dauser* *first woman Captain*
1946–1950	Nellie Jane DeWitt *first Director*
1950–1954	Winnie Gibson
1954–1958	W. Leona Jackson
1958–1962	Ruth A. Houghton*
1962–1966	Ruth A. Erickson
1966–1970	Veronica M. Bulshefski
1970–1975	Alene B. Duerk,* *first woman Admiral (1972)*
1975–1979	Maxine Conder
1979–1983	Frances T. Shea
1983–1987	Mary J. Nielubowicz
1987–1991	Mary F. Hall
1991–1994	Mariann Stratton
1994–	Joan M. Engel

**Served in the Naval Reserve*

Models attired in the Navy Nurse Corps uniforms of World War II (left) and World War I

a September letter from Higbee to Beatrice Bowman, a chief nurse.

> The Corps now numbers about 700 nurses and of these the regular corps is about 225. The remainder are divided into two groups. One, the enrolled nurses of the Naval Coast Defence [*sic*] Reserve, who have been organized in groups of 10 to 20 around some hospital, and who are enrolled for the emergency of war. They receive a retainer fee of $1.00 a month while in the provisional grade, and a fee of $100.00 a year when they have passed an examination for confirmed grade. [That group was designated Nurse, USNRF] . . . .
>
> The second group of temporary nurses are the "Reserve Nurses, U.S.N." who are appointed in accordance with the law establishing the Nurse Corps. . . . These nurses are members of the Hospital Units organized by civilian institutions and financed by the civilian contribution. They come to the Navy through the Medium of the Red Cross but when assigned to active duty they at once become part of the Naval Personnel. The Unit is moved as a whole, doctors, nurses and all employees. These "Reserve Nurses" are the only ones who have as yet been ordered to overseas duty.[15]

Thus, the Reserve Navy Nurses—not the Regulars—would be the first to serve overseas. Higbee expressed concern about the Regulars' reaction. After all, she observed, chief nurses of the Reserve units received only "rapid fire training" in the duty that was familiar to all Regular Navy nurses. Higbee's opinion was that it was "a little strange that the trained and tried should be kept at home and the reserves be given the fighting chance." Yet, she concluded: "[T]his is the policy of the entire Government and there is nothing to do but accept it. . . . [Navy staff] is required also to speed the departing reservist and console the regular who protestingly remains."[16]

Who served where was not the only item of concern for differentiating the Regular and Reserve nurses. In 1917 the first "street" or "outdoor" uniform became available. It was optional except when going abroad. This meant that overseas-bound Reserve nurses would be given uniforms before Regular nurses. Because the uniform cost $70 (a considerable sum), there was even some discussion of transferring Reserve Nurses, USN to the USNRF so that they would receive a uniform gratuity.[17]

Who could wear the Nurse Corps insignia also was discussed. When the Secretary of the Navy ruled that there should be no distinctive marks between Regulars and Reserves, Higbee concluded that Reserves were authorized to wear the Nurse Corps insignia, despite her personal conviction that only Regulars should wear the pin.[18] The pin issue may have been complicated by the fact that Navy nurses were not allowed to wear their Red Cross pins. The Red Cross pins, individually inscribed and issued for life to enrolled nurses, were worn with great honor and pride.

Authority was also a controversial issue. In 1918, for example, a Reserve serving as an assistant chief nurse was advised to transfer to the Regular Nurse Corps because of the likelihood that she might have to act as a chief nurse supervising Regulars; it was thought to be inadvisable to have a Reserve Nurse in

Navy nurse in the second floor operating room of Building Four, United States Naval Medical Hospital and Medical School, in 1924

authority over Regular Nurses. Higbee claimed that such transfers were the method followed by the Medical Department and were no reflection on the Reserves—its purpose was to eliminate the possibility of misunderstandings.[19] Navy Nurses—Reserves and Regulars—fully met the challenge of wartime service. By war's end, the total number had risen to 1,476. World War I was the first war for which the Navy had a corps of trained female nurses.

Navy Nursing in Peacetime

NRF nurses were demobilized by June 30, 1920. Those wishing to remain with the Navy had to transfer to either the Regular Navy for a three-year term or to Reserve Nurse, USN, which required service of at least one year when needed. Thus, the 1920s saw a decline in strength.

In 1925 the Congress passed a law that restricted membership in the Naval Reserve to "male citizens" only. That terminology was interpreted to mean that female nurses could no longer be part of the Navy Reserve, even though their service fit the criteria for one of the three categories created by the law. The Reserve Nurse found herself with a "very indefinite status." Not surprisingly, no Reserve Nurses were appointed or ordered to active duty after June 1926; the few remaining Reserves on inactive status were discharged in 1930.[20]

Return to Service

While the 1925 law had wiped out nurses with one word (male), the Naval Reserve Act of 1938—anticipating the hostilities of World War II—restored them in with one sentence. It stated explicitly that "female registered nurses may be appointed in the Volunteer Reserve."[21] By 1939, when the strength of the corps was just over 440, the Navy called for fourteen hundred nurses for the Naval Reserve. The Red Cross, as it had for World War I, was called upon to share its list of available professionals with BUMED.Women who agreed to join the Naval Reserve Nurse Corps were allowed to remain members of the Voluntary Nursing Service of the Red Cross. On September 1, 1939, Mildred Patet and Effie Shaw became the first to execute the oath of office and be appointed in what was now called the Naval Reserve Nurse Corps. Within fourteen months, a total of 887 nurses had been appointed, and there were 791 applications pending.[22] The recruitment program was a success.

Before long, nurses were experiencing Navy life. On November 15, 1940, eight were ordered to report for active duty; the following month, twelve more were called, and twenty more in January. Thousands would follow.

From 1939 to 1946, Sue S. Dauser was superintendent of the Nurse Corps. An experienced World War I nurse, Dauser eventually became the first woman to wear Navy Captain stripes. She entered her position commanding a corps of 1,036 and built it to a corps exceeding eleven thousand.

Of the eleven thousand serving on active Naval duty during the war, more than nine thousand were Reservists. Eligibility requirement for Reserves had changed only slightly since the earliest days—the age requirement was adjusted

A Marine leads Navy Nurses in drill, December 10, 1942.

to twenty-one years of age (with an upper limit of forty years), U.S. citizenship (or naturalized at least ten years), graduation from an accredited school of nursing, registered nurse status, unmarried, membership in the American Nurses Association, and possession of credentials and employment records establishing mental, professional and moral qualifications. Additional examinations were no longer imposed. Regular Navy nurses had a cutoff age of twenty-eight years. Around 1945, Regulars could marry without being forced to resign.

By the time of World War II, experienced nurses were paid $150 per month with full maintenance. Both Regulars and Reserves served the six-month probationary period and received uniforms when called to active duty. The Red Cross still controlled recruiting for the Reserves.

Throughout the 1940s, Navy nurses served in hospitals and dispensaries in

the United States and overseas, in six Hospital Corps schools, on twelve hospital ships, and on air evacuation teams. They saw enemy action, and eleven were prisoners of war for almost thirty-seven months in the Philippines. Their members were honored with 303 military awards.[23]

In 1944 the Navy began a flight school for nurses—the Navy School for Air Evacuation of Casualties, located at the Naval Air Station in Alameda, California.[24] Nurses also found themselves stationed in such recreational areas as Sun Valley, Idaho, and Yosemite, California, where they served at wartime rehabilitation hospitals.

The war years also brought significant legislative changes. Various laws defined pay and allowances, relative rank, commissioned rank, and a Women's Reserve. Some of the reforms were intended as wartime measures only, requiring eventual new legislation. By the armistice, Surgeon General Ross T. McIntire requested a waiver of the twenty-eight-year age maximum for transferring to the Regular Navy. He sought an upper-age limit of thirty-eight for Naval Reservists because of the high incidence of academic degrees, experienced instructors, and trained specialists in the thirty-to-forty age group. His request was approved by the Secretary of the Navy on September 13, 1945.[25] It is interesting to note that such reasoning continues to be used for recent expansions for commissioning in the Reserves.

Rapid Demobilization and Peacetime

The Nurse Corps, as all parts of the Navy Medical Department, experienced a "critical shortage of personnel" as war-weary veterans eagerly returned to civilian life. At the same time, however, the Navy was attempting to accelerate and expand rehabilitation facilities for disabled personnel. From a peak staffing of 11,086 in July 1945, the Nurse Corps dropped to 4,459 by July 1946.[26]

From 1946 through 1950, therefore, there was a flurry of activity for organizing the Reserves. Helen M. Fitzgerald's study of the Nurse Corps concludes that this was the first time an effort was made to build a Naval Reserve force on inactive status. Experienced Navy nurses served as the nucleus of this reserve.[27] The rapid demobilization immediately following the war resulted in a Nurse Corps of about 2,100 (293 Reservists) by July 1, 1947, with an additional 3,280 inactive Reserves. By July of 1949 there were 2,009 Navy nurses (267 Reservists) with 5,389 inactive Reservists.[28] The Red Cross was still assisting with the recruitment of Reserve nurses.

Appointees to the Reserve Nurse Corps could be twenty-one to thirty-nine years old, and married with no children. They received a $100 uniform allowance and were eligible for retirement at age sixty after twenty or more years of service.[29] Inactive Reserves were organized into voluntary medical units with a minimum of ten Reservists. The units were obligated to provide training including correspondence courses and programs. Other requirements included two weeks of active duty, attendance at specific conferences, and achieving fifty points on other activities. In addition, selection boards were established for promotions. This

March 1945 liberation of nurses who had been held as prisoners of war

probably was the birth of the model currently in use for the Naval Reserve.

Another postwar idea was Captain Nellie Jane DeWitt's suggestion that there be a full-time billet (position) in BUMED in connection with the Reserve Corps program. She thought "an outstanding Reserve Corps officer of sufficient rank to have distinction (senior LT or LCDR) might give an added impetus to the program."[30] Her suggestion was not acted upon for another forty years, until the appointment of Captain Margaret Armstrong in the late 1980s. DeWitt also suggested that the Nurse Corps, USNR, be divided into those with active service, and new appointees with no service. This might relate to the dilemma of having a mixed corps of World War II veterans with extensive experience

and newly recruited neophytes. There was no indication that this ever occurred.

If there is an anniversary to be celebrated by the Navy Nurse Corps, it is probably April 16, 1947, when the Army-Navy Nurse Act was signed into law. That law established a permanent Nurse Corps in the Army and Navy, a well as a Nurse Corps Reserve. Furthermore, it provided for commissioning, permanent ranks, and authority. DeWitt became the first Director of the Navy Nurse Corps. Before that, she had held the title of Superintendent. This act was comprehensive in bringing together all aspects of nurses as a legitimate part of the Navy.

U.S. Naval Hospital at Sun Valley, Idaho, ca. 1944

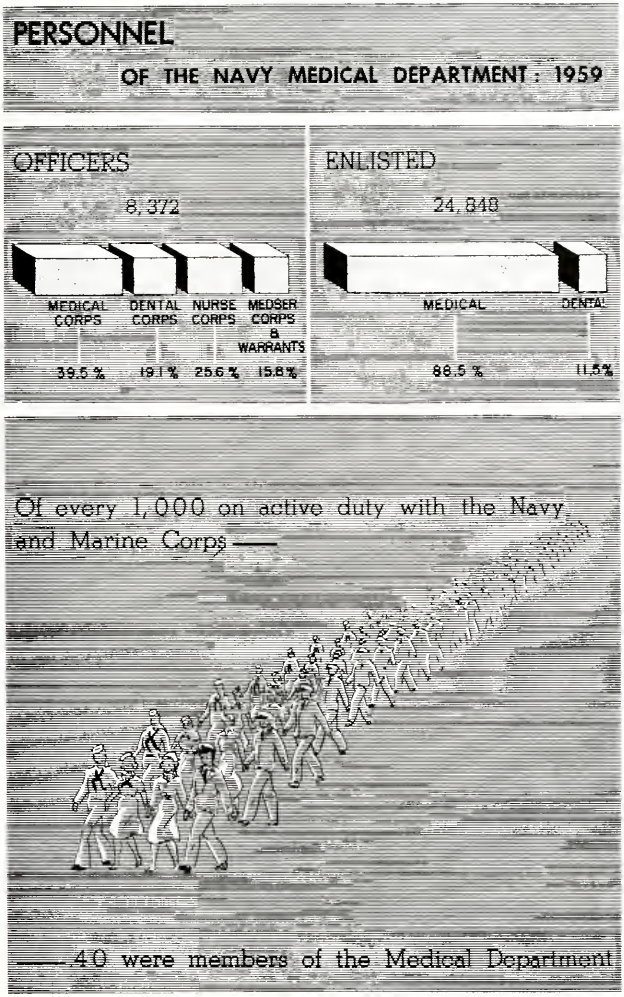
Korea

That flurry of activity around the organization of the Reserves led directly into the Korean conflict, where once again there was a need for the rapid expansion of the Nurse Corps. In 1950 there were 1,942 Navy nurses on active duty (437 reservists). Within a year that number expanded to 3,238, of which 1,723 were Reservists.[31] At various times during the war years, there was authority to recall Reservists to active duty to meet the needs of the Navy.

From 1953 until 1960 the corps was stabilized at about two thousand nurses. (Legislation in 1955 authorized male nurses, although it was ten years before one was commissioned.) All new appointments were being made in the Reserves. Reservists had to volunteer for active duty and were released after two years.

Nurses were integrated into the mainstream of Navy life. The old nurses' quarters were closed, for example, and there were significant opportunities in training and education. In 1957 a Nurse Corps Candidate Program was established, offering benefits to nursing students. Newly commissioned nurses were offered an eight-week indoctrination course at Women Officers School in Newport, Rhode Island, in 1959. The fifty-four nurses attending school full time in 1960 studied vastly different subjects than did the eight nurses in 1923 who were sent to Miss Farmer's School of Cookery in Boston to become Navy dieticians.[32]

By 1959 there were 2,140 Navy nurses on active duty—928 Regular and 1,212 Reserve. "The Navy Nurse Corps had a need for a continuing influx of new



By 1959, Navy Nurses accounted for slightly more than a quarter of all U.S. Navy Medical Department officers.

Throughout the first fifty years of their existence, an important responsibility of Navy Nurses was instruction of members of the Hospital Corps. Above, a Navy Nurse conducts class.

nurses" according to Captain W. Leona Jackson, Director of the Corps.[33]

Conclusion

But some things have not changed. Workman's 1926 article on nursing in the Navy is an accurate description of modern benefits—travel opportunities, the "homeyness" of the environment, regularity of hours, the salary, living expenses, pay that continues during a sick period (very important to nurses in the 1920s), complete uniform outfit, retirement, and special courses of study. The one benefit that is no longer valid is Workman's observation that Navy nursing was easier than civilian nursing because Navy patients were "almost exclusively men" and were therefore "more easily made comfortable than women."[34] Today, of course, all the military services actively recruit women.

Together, Regular and Reserve nurses have worked in the Navy. Their history is a shared one. A continuing effort to analyze the history of one will also bring to light accomplishments of the other. Navy medicine has always relied on the Reserve nurses to augment the regular forces even during peacetime. It appears that the planning for the defense of the nation in the 1990s also relies on the support of a well-trained reserve military force.

Notes

1. Beatrice J. Bowman, "History of Nursing in the Navy," *American Journal of Nursing* 28 (1928): 887.

2. Ibid., 885.

3. *History of the Medical Department of the United States Navy, 1945–1955* (Washington, D.C.: U.S. Government Printing Office, 1958), 55.

4. Ibid., 55–56.

5. *U.S. Statutes at Large,* 60th Cong., 1 Sess. (1908), 35:146 (Public Law 115).

6. "The Navy Nurse Corps," *American Journal of Nursing* 9 (November 1908): 91–92. In history books these nurses are identified as the "Sacred 20," but that number has not been verified.

7. Esther V. Hasson, "The Navy Nurse Corps," *American Journal of Nursing* 9 (March 1909): 411–12.

8. Hasson, "The Navy Nurse Corps," *American Journal of Nursing* 9 (January 1909): 267.

9. Bowman, "History of Nursing in the Navy," 887.

10. U.S. Navy, *Regulation and Instructions for the Nurse Corps* (Washington, D.C.: Department of the Navy, 1909), 5.

11. Ibid., 7.

12. Bowman, "Comments on Navy Nursing," *American Journal of Nursing* 14 (July 1914): 838.

13. Hasson, "The Navy Nurse Corps," *American Journal of Nursing* 9 (March 1909): 412–13.

14. Clara D. Noyes, "Department of Red Cross Nursing," *American Journal of Nursing* 28 (February 1928): 173.

15. Lenah S. Higbee to Beatrice J. Bowman, Sept. 27, 1917, pp. 1–2, Nurse Corps Chiefs File, Historian's Office, Bureau of Medicine and Surgery (hereafter cited as BUMED), Department of the Navy, Washington, D.C.

16. Ibid., 2.

17. Higbee to Bowman, Oct. 9, 1918, Correspondence File, Box 1, Navy Nurse Corps, Operations Archives Branch, Naval Historical Center, Washington, D.C.

18. Higbee to Bowman, Feb. 20, 1919, ibid.

19. Higbee to Bowman, June 25, 1918, ibid.

20. Memorandum, Nellie J. DeWitt to Colonel Blanchfieldt, Dec. 5, 1945, Procurement of Nurses Folder 2b, Box 15, Navy Nurse Corps, Naval Historical Center.

21. *Naval Reserve Act,* Public Law 732, June 25, 1938, p. 1176.

22. "Nurses of Naval Reserve Ordered to Active Duty," press release by Department of the Navy, Nov. 8, 1940, Inactive Reserve (1940–1972) File, Box 11, Navy Nurse Corps, Naval Historical Center.

23. BUMED 3433, Mar. 1, 1950, p. 2, Statistics Folder 1, Box 19, Navy Nurse Corps, Naval Historical Center.

24. "The Task Force in White," n.s., n.d. (ca. 1945), 25, History File, Office of OP093N1R, BUMED.

25. Surgeon General McIntire to the Secretary of the Navy, Aug. 25, 1945, Procurement of Nurses Folder 1, Box 15, Navy Nurse Corps, Naval Historical Center.

26. *History of the Medical Department of the United States Navy,*16–17.

27. Helen M. Fitzgerald, "A History of the United States Navy Nurse Corps from 1934 to the Present" (master's thesis, Ohio State University, 1968), 65.

28. *Surgeon General Reports, Statistics, 1927–1950,* Surgeon General Reports File, Box 19, Navy Nurse Corps, Naval Historical Center.

29. Capt. Wylie, "Legislation Pertinent to the Reserve Nurse Corps," speech, St. Albans,

N.Y., Aug. 1949, Procurement of Nurses Folder 2b, Box 15, Navy Nurse Corps, Naval Historical Center.

30. Memorandum, N. J. DeWitt to Chief, Bureau of Medicine and Surgery, May 8, 1946, Procurement of Nurses Folder 2b, Box 15, Navy Nurse Corps, Naval Historical Center.

31. *Surgeon General Reports, Statistics, 1927–1950.*

32. "Miss Farmer" was Fannie Farmer, currently known for her candy.

33. Memorandum, Code 3 to Code 32 (W. Leona Jackson), Sept. 27, 1955, Naval Nurse Corps Program History (1947–1960) File, Box 14, Navy Nurse Corps, Naval Historical Center.

34. Hannah Workman, "Nursing in the Navy," *U.S. Naval Medical Bulletin* 24 (1926): 607.

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Reflections on the Changing Image of Nurses in Wartime

The contributors to this issue have illustrated how the emergencies of the battlefield repeatedly proved the superiority of the professional nurse over the untrained volunteer. Furthermore, each wartime experience sharpened the awareness of the nation's dependence on nurses and reinforced the need to develop adequate training for caregivers.[1]

This issue of *Caduceus* has attempted to fill the void in the public's understanding of nursing by focusing on the heroic part played by nurses in wartime. Too often, that role has been interpreted in superficial or trivial ways—in Hollywood films, for example, where the depictions have tended to portray wartime nurses as melodramatic, sentimental, and romantically involved. The bravery and courage of military nurses under dangerous conditions has not been addressed.[2]

Nurses in Action: Wars of the Twentieth Century

The global conflicts of the twentieth century challenged nurses and nursing as no other wars had done. New nursing skills were called for by both the civilian and military populations, creating significant drains on the available supply of graduate nurses.

World War I had been the first war in which nurses were exposed to the actual battlefield. Nurses, along with troops, were constantly threatened by frequent shelling, demoralized by the deaths of colleagues, forced to tolerate sordid living conditions, and exposed to communicable diseases. Such conditions of "overwhelming suffering and awesome responsibility" prompted nurses to abandon their "customary obedience to authority" and assume ever-greater independence in judgment.[3]

Perhaps the most crucial aspect of modern global warfare, beginning with World War I, was the realization by nurses that they were faced with the dilemma of caring for soldiers who would probably be sent back to the battle. Could healing be justified for destructive purposes? Reverence for all life against the violent destructiveness of war was indeed a contradiction. The experience of change and the effect of war

by M. Patricia Donahue
Guest Editor

upon the lives of nurses transformed their image in radical and irreversible ways.[4]

Each war also increased the demand for trained nurses. In World War I and World War II, numbers of nursing students were increased through a variety of mechanisms, including nationwide campaigns that appealed for public support of the war effort. Both wars brought on nursing shortages, although not until passage of the Bolton Act in 1943 was the United States Cadet Nurse Corps established, which provided for an accelerated and expanded program of education for students entering approved schools of nursing. The thirty-month program furnished tuition, fees, uniforms, and monthly stipends for students, as well as postgraduate grants for additional study. In return, nurses pledged to serve wherever needed in military or civilian agencies for the duration of the war and six months afterward. Students responded enthusiastically. The original two-year quota for the Cadet Nurse Corps was 125,000; in the first twelve months, 65,000 were recruited, followed by 60,000 the next year.[5]

An enduring legacy of World War II was the full integration of nurses into the military structure. Their contributions could no longer be ignored. Wherever American troops were stationed around the world, nurses could be found. They were an integral part of the developing mobile army surgical hospital (MASH) units, which reached their greatest use in the Korean War. MASH units operated with a usual complement of ten physicians, twelve nurses (including two anesthetists), and ninety corpsmen who could quickly break camp and travel at a moment's notice.

Improved air transport for evacuation and a new generation of drugs (especially sulfonamides and penicillin) further expanded the range of nursing care; as a result, the death rate for American troops declined with each war. Flight nursing, an important innovation of World War II, was established through the Air Surgeon's Office in September of 1942; the program prepared qualified nurses to rapidly convert transport planes (C-45 Commandos, C-47 Skytrains, and C-54 Skymasters) into flying ambulances. These transports had dual functions; they were used to transport cargo and troops to battle and then became ambulances for the return trip. Because they were not marked with the Geneva Red Cross as noncombatants, however, the planes were not immune from enemy attack. Thus, flight nurses performed under highly dangerous and pressure-filled circumstances.[6]

In Korea, helicopters were added to the MASH units, allowing for even more rapid air evacuation of the wounded. As many as 3,925 wounded were aeromedically evacuated on a single day, December 5, 1950. The MASH unit thus became the first hospital to which the wounded were sent (seriously wounded were transported to either South Korea or medical centers in Japan). By the end of the war, more than 350,000 patients had been evacuated by propeller-driven cargo aircraft. Stateside, the Air Force Nurse Corps mobilized its resources and accelerated its training programs.[7]

The Vietnam War

Vietnam was a war of contrasts. There was no traditional frontline, nor were there secure road networks in combat areas. Hospitals could not follow and support tactical operations; ground evacuation was next to impossible. All hospitals became fixed installations, and helicopters became the primary means of evacuation.

To be sure, Vietnam was different for a variety of reasons. Television portrayed the war in homes throughout the United States and the world, but reality was difficult to ascertain. Conscientious objectors fled to Canada, went underground, or were jailed. It was an extremely unpopular war with thousands of people marching in protest and hundreds arrested trying to storm the Pentagon. Student unrest erupted on campuses across the country. Minorities were drafted in disproportionate numbers.

When American military nurses first became involved in March 1962 they were unprepared for the kinds of injuries they saw.[8] Antipersonnel bombs and small arms fire inflicted massive, multiple injuries, and the later napalm and white phosphorous caused previously unseen burns. Traumatic amputations, enormous blast wounds, and flesh burned down to the bone were horrific and frequent.[9] Vietnam was also a "dirty" war in which traumatic injuries were penetrated with dirt and debris.

As in all wars, the presence of female nurses in Vietnam lent reassurance, comfort, and emotional support. That support seemed especially welcome in the devastation of southeast Asia, "an alien world thousands of miles from home." Troops were astonished and reassured at the sight of an American woman so close to the battlefield. They "seemed to gain a sense of security and comfort from the women's presence, a sense of a more normal way of life, a reminder of home."[10]

Vietnam shares a curious relationship with the American Civil War—there is no consensus on the actual number of military women who served. The Department of Defense, for example, stipulates that about 7,500 American women were on active military duty, while the Veterans Administration indicates more than eleven thousand. Among the total loss of American military life in Vietnam—more than 58,000—it is known that there were eight female and two male nurses. In addition, nurses suffered emotionally from Post-Traumatic Stress Disorder (PTSD).[11]

Desert Storm

In the most recent military conflict, "Desert Storm," nurses and women were involved in crucial ways. About 32,000 women served, and women made up more than 10 percent of the total U.S. military and almost 40 percent of military medical units. Although much has been written about the history, military aspects, and chronology of the Gulf War, information about the role of nurses is sparse. The reality is, however, that nurses, too, were faced with the threat of biological and chemical warfare and SCUD attacks and tolerated the brown, desolate, dry Gulf landscape. The aftermath of this war on nurses remains to be

seen, but it is possible that they will also suffer from the illusive Persian Gulf Syndrome, which is already taking a toll on servicemen; Post-Traumatic Stress Disorder may also be experienced.[12] Desert Storm reaffirmed the courage of military nurses, particularly their willingness to care for the sick and the wounded, regardless of risks involved.

Nursing: A Reflection of Social Reality

Nursing is an occupation known to everyone, yet not really understood. Its role in wartime deserves special attention. Nursing changes, grows, and advances in response to perceived social needs. It not only parallels the development of the social welfare system but also reflects prevailing attitudes toward sickness and health. Nursing roles, functions, and responsibilities have changed in response to the impact of societal changes and events. The progression of nursing has been more than a technique and more than a highly skilled trade—it has been a dynamic process. The elements of soul, mind, and imagination are incorporated within that process: a sensitive spirit, intelligent understanding, and creative inspiration have all provided the foundation for nursing.

The heritage of nursing is rich, a record of pioneering that reflects new advancements with each generation. From earliest times, nurses have dealt with the most basic of human needs and fears. Regardless of location, nurses are in daily contact with human beings in need—people crying, immobilized, angry, frightened, depressed, and only occasionally joyful. They live with the outcome of a diagnosis made or missed, the crisis of faith in a higher being or a physician, and the ever-present knowledge of change, decline, disability, and death.[13]

In wartime, all of those emotions are present—heightened by hostile and unfamiliar surroundings, the danger of attack, and separation from loved ones. In wartime, nurses continue to touch the lives and privacies of others, with the additional responsibilities of national and military purpose. Wartime service has redefined nursing in a unique way that differs from nurses' traditional relationships with the general public, corporations, professional colleagues, policy makers, and health care administrators and agencies.

Through its long history, nursing has been both simple and complex. Although concrete in result, it is abstract in practice. One might thus speculate that the true art and science of nursing with its caring spirit will never be captured, that nursing defies expression! Consequently, society has been slow to comprehend the true worth of nursing. A reexamination of nursing's contribution to wartime is overdue. Just as the professionalization of nursing has been regarded as "perhaps the most important single element in reshaping the day-to-day texture of hospital life," the professionalization of military nursing has played a dramatic role in the health and welfare of American troops.[14]

The military, perhaps even more than the contemporary hospital, offers a unique environment in which to study the professionalization of nursing—a high-tension culture traditionally dominated by men that presents unique

technical and philosophical challenges to nurses.

Conclusion

An important element of the progression of nursing in the twentieth century has been the realization of nursing's worth in wartime and the willingness of trained nurses to accept the challenges of wartime service. Federal support of nursing and nursing education—matched by enthusiastic responses by nurses willing to serve in the military—has been observed with each of the wars of this century.

The legacy of military nurses is profound, as is the legacy to society of the whole of nursing. Whether individuals, groups, or societies can ever completely understand the essence of nursing is perhaps a moot point. What is important, however, is the fact that nurses have, both in peacetime and wartime, given undeniable, beneficial service under extreme circumstances. They have invested in the future of this country as they have diligently worked with tenderness, compassion, and expertise to comfort the suffering and save lives. It is time that nurses become *loudly heard* and *greatly noted.*

■

Notes

1. M. Patricia Donahue, *Nursing: The Finest Art—An Illustrated History* (St. Louis: C. V. Mosby Company, 1985), 395.

2. Philip A. Kalisch and Beatrice J Kalisch, *The Changing Image of the Nurse* (Menlo Park, Calif.: Addison-Wesley Publishing Company, 1987).

3. Linda S. Beeber, "To Be One of the Boys: Aftershocks of the World War I Nursing Experience," *Advances in Nursing Science* 12 (1990): 39.

4. Philip Kalisch and Beatrice Kalisch, *Changing Image of the Nurse.*

5. Philip A. Kalisch and Beatrice J. Kalisch, *Advance of American Nursing* (Boston: Little, Brown and Company, 1979), 473–75.

6. For a detailed account of the dangers faced by flight nurses, see ibid., 460–64, and Philip A. Kalisch and Margaret Scobey, "Female Nurses in American Wars," *Armed Forces and Society* 9 (1983): 228–29.

7. Rita K. Chow et al., "Historical Perspectives of the U.S. Air Force, Army, Navy, Public Health Service and Veterans Administration Nursing Services," *Military Medicine* 143 (1978): 457.

8. Elizabeth M. Norman, *Women at War: The Story of Fifty Military Nurses Who Served in Vietnam* (Philadelphia: University of Pennsylvania, 1990); Robert M. Hardaway, *Care of the Wounded in Vietnam* (Manhattan, Kan.: Sunflower University Press, 1988).

9. Vietnam Veterans' Association, "Women Vets Profiled in New VA Study," *Veteran* 5 (October 1985); Kathyrn Marshall, *In the Combat Zone: An Oral History of American Women in Vietnam, 1966–1975* (Boston: Little, Brown and Company, 1987), 6–7.

10. Jeanne M. Holm and Sarah P. Wells, "Air Force Women in the Vietnam War," in *Celebration of Patriotism and Courage: Dedication of the Vietnam Women's Memorial, November 10–12, 1993,* 46.

11. Doreen Spelts, "Nurses Who Served—And Who Did Not Return," *American Journal of Nursing* 86 (1986): 1037–39; Dan Freedman and Jacqueline Rhoads, eds.,

Nurses in Vietnam: The Forgotten Veterans (Austin: Texas Monthly, 1987); Jeffrey Walsh and James Aulich, eds., *Vietnam Images: War and Representation* (New York: St. Martin's Press, 1989); Lucy R. Lippard, *A Different War* (Seattle: Whatcom Museum of History and Art and Real Comet Press, 1990); Julene Fischer, *Images of War* (Boston: Boston Publishing Company, 1990).

12. Peter David, *Triumph in the Desert* (New York: Random House, 1991), 154–59. There was a certain irony that Saudi Arabian women were not permitted to drive cars or even show their faces. Because of Saudi Arabian customs, American military women were not permitted to wear shorts, jog, or go shopping unless accompanied by a man. Yet, they shared all duties except those on the front lines.

13. Donna Diers and D. Evans, "Excellence in Nursing," *Image: The Journal of Nursing Scholarship* 12 (1980): 27–38.

14. Charles E. Rosenberg, *The Care of Strangers* (New York: Basic Books, 1987), 8–9. Bonnie Bullough and Vern L. Bullough, among other historians, assert that nursing's dependence on the development of modern medicine and the hospital complex has often been told, while the dependence of modern medicine and the development of the hospital on the development of nursing has not; in the Bulloughs' opinion, "The individual most responsible for the development of modern hospital medicine is the nurse." See their *The Emergence of Modern Nursing* (New York: Macmillan Company, 1964), 214. See also E. M. Vreeland, "Fifty Years of Nursing in the Federal Government Nursing Services," *American Journal of Nursing* 50 (1950): 626; Diers and Evans, "Excellence in Nursing," 27–38; and Diers, "What Is Nursing?" in *Current Issues in Nursing*, 4th ed., ed. Joanne McCloskey and Helen K. Grace (St. Louis: Mosby, 1994), 5–14.

Announcements

The Vietnam Women's Memorial Project

The Vietnam Women's Memorial Project was conceived with three goals: to place a memorial honoring the women who served during the Vietnam War at the Vietnam Veterans Memorial in the nation's capitol; to identify the 265,000 military and civilian women who served in Southeast Asia; and to universally educate about the service of women during that war. Incorporated in 1984 under the laws of the State of Minnesota, registered in the District of Columbia—home of its national office—the Vietnam Women's Memorial Project continues to meet its goals.

The November 11, 1993, dedication of sculptor Glenna Goodacre's bronze memorial drew to a close the first objective and provided a visibility that worked to fulfill the second and third. Today, founder and chair Diane Carlson Evans, along with the Board and staff, persist in seeking out the women who served in the Air Force, Army, Navy, Marine Corps, and Army Special Services, as well as those who worked with the Red Cross, USO, and other American organizations.

The "Sister Search" network assists in informing women of proposed or ongoing research on physiological, psychological, or sociological issues related to their service. The network also works to determine individual needs, along with providing access to support groups and to the experiences of fellow veterans. Finally, "Sister Search" gives voice to the special role women have in the current discussions surrounding the call to arms, the role of women in the military, and the access of women to veterans' benefits.

Until recently, women vets had been largely forgotten. They are missing from the histories written about Vietnam and from the studies of Vietnam veterans. Until November 1993, they had been missing from the monuments, celebrations, and speeches dedicated to the era. The women of the Vietnam era, all volunteers, hold a unique place in American history. Most of their stories are yet to be told. To date, the Project has received information from nearly thirteen thousand Vietnam women veterans.

The national headquarters of the Vietnam Women's Memorial Project in Washington, D.C., actively continues to document women veterans, and their fundraising efforts continue for that purpose. The address is: Vietnam Women's Memorial Project, Inc.; 2001 "S" Street, NW; Suite 302; Washington, DC 20009. A list of Project publications and commemorative items is available at that address.

Additional information about current activities is given in the *1994 Annual Report of the Vietnam Women's Memorial Project* (Washington, D.C.: Vietnam Women's Memorial Project, 1994).

Surgical Nurses Research

The Southeastern Surgical Nurses Association invites submission of original abstracts of papers for presentation at the association's annual meeting, to be held February 5–7, 1996, in Tampa, Florida. Abstracts should be approximately two hundred words in length, double spaced, and include three learning objectives for those attending the presentation. Preference will be given to papers dealing with care of the surgical patient, including pre-operative, intra-operative, or post-operative care. Fifteen copies of the abstract, plus a one-page curriculum vitae, should be submitted by August 1, 1995, to Southeastern Surgical Nurses Association; P.O. Box 330; Pelham, AL 35124.

History of Dermatology

Papers are now being requested for the Seventeenth Annual Samuel J. Zakon Award in the History of Dermatology. The competition is open to historians and dermatologists in practice or training. Manuscripts should be submitted by October 1, 1995, to John Thorne Crissey, M.D., Chairman, Samuel J. Zakon Award Committee; 608 Sierra Madre Boulevard; San Marino, CA 91108. Topics may relate to any aspect of the history of dermatology not heretofore published. Both the Zakon Prize and the Zakon Award are given by the children of Dr. Samuel J. Zakon, an outstanding Chicago dermatologist and historian.

Online Artifact Cataloging

The Cleveland Health Sciences Library announces publication of *A Manual for Cataloging Historical Medical Artifacts Using OCLC and the MARC Format.* The manual, written by the Ohio Medical Artifact Cataloging Project, is the result of a five-year effort underway at the Dittrick Museum of Medical History and the Cleveland Health Sciences Library to catalog historical medical artifacts using a MARC (Machine-Readable Cataloging) format. The records are then added to OCLC, the online union catalog. The manual includes information specific to the identification and indexing of medical artifacts and serves as a guide for cataloging any artifact in the MARC format.

One copy per request is available at no cost from the Dittrick, with additional copies available for a $3 postage and handling charge. A second guide for researchers seeking medical artifact information through OCLC will be available later this year.

Orders and requests for further information should be directed to Dr. Patsy Gerstner, Director; Dittrick Museum of Medical History; 11000 Euclid Avenue; Cleveland, OH 44106-1714.

New Medical History Monograph

Three personal views on health care from the 1890s through the Great Depression of the 1930s are presented in a new book published by Southern Illinois University School of Medicine. *Practice & Progress: Medical Care in Central Illinois at the Turn of the Century* is part of the Pearson Museum Monograph Series produced by the Department of Medical Humanities.

The authors are Susan Harmon, a family practice physician in Lincoln, Illinois,

who writes about the early Springfield practice of Dr. Elizabeth Matthews; J. Edward Day, former Postmaster General under John F. Kennedy, who chronicles the career of his father, Dr. James Almond Day; and the late Dr. Thomas Masters, who documents the 1918 influenza outbreak in Springfield as covered by the city's two newspapers.

Practice & Progress: Medical Care in Central Illinois at the Turn of the Century is available for $12.95, plus $3 for shipping and handling, from the Department of Medical Humanities–1113; Soutern Illinois University School of Medicine; P.O. Box 19230; Springfield, IL 62794-9230.

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Readers are invited to forward announcements of programs, publications, and exhibits to *Caduceus: A Humanities Journal for Medicine and the Health Sciences*, Department of Medical Humanities–1113, Southern Illinois University School of Medicine, P.O. Box 19230, Springfield, IL 62794-9230.

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Page 49: *Medical Statistics, U.S. Navy, Occurrence of Diseases and Injuries in the United States Navy for the Calendar Year 1959* (Washington, D.C.: U.S. Government Printing Office, 1961), 14.

Page 50: *The History of the Medical Department of the United States Navy, 1945–1955* (Washington, D.C.: U.S. Government Printing Office, 1958), 68.

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The Editor will consider manuscripts not greater than thirty pages on subjects of interest to a multidisciplinary audience. Manuscripts should be double-spaced on 8 1/2" by 11" paper. Electronic submissions are welcome. Footnote style should follow the Fourteenth Edition of *The Chicago Manual of Style*, published by the University of Chicago Press. Illustrations (glossy prints are preferred) are welcomed and will be printed without charge to the author. All illustrations should be accompanied with proper permissions and full citation.

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The Editor also welcomes unsolicited manuscripts. Information on style is given on the inside back cover of this issue.